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ABSTRACT

The Comprehensive Child Development Act of 1988 provided for the establishment of Comprehensive Child Development Program (CCDP) projects to be administered by the Administration on Children, Youth and Families (ACYF). A total of 24 CCDP projects were funded through 1990. The CCDP works with the family as a unit and integrates services across agencies. Services provided include child health care, licensed day care, developmentally appropriate education, and vocational training for parents. This document reports the findings of the ACYF's first evaluation of the CCDP projects. Findings are discussed in terms of: (1) the CCDP project sites; (2) the families enrolled in the projects; (3) interagency coordination and special issues encountered in implementing projects; (4) the case management format of service delivery and the services provided by the projects; (5) attrition; and (6) site visits. Factors that facilitated project start-up are discussed and some early successes are reported. Two extensive appendixes include a description of management support activities and products, and profiles of the 24 CCDP programs. Each profile describes the project's area of operation and philosophy, and lists the services provided to adults and children. (BC)

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Comprehensive Child Development Program: A National Family Support Demonstration

PS 020382

FIRST ANNUAL REPORT

Head Start Bureau
Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

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Head Start Bureau
Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

Contract No. 105-89-1635

Comprehensive Child Development Program— a National Family Support Demonstration

FIRST ANNUAL REPORT

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FOREWORD

The Administration on Children, Youth and Families (ACYF) has established a new and innovative program—the Comprehensive Child Development Program. This program is designed to provide integrated, comprehensive, and continuous support services to children from low-income families from birth to age 6 and to their parents and other household members. The underlying philosophy of the Comprehensive Child Development Program is that children are an integral part of the larger family unit and that this unit must be served in a comprehensive manner if the cycle of poverty in which these children and families are entrenched is to be broken. It is a philosophy based on the culmination of over 30 years of research on early intervention programs that hold that intervention strategies are most effective if they begin early and serve the family in a holistic manner.

The Comprehensive Child Development Program is also a demonstration project that is designed to test and evaluate the assertion that providing services earlier, more comprehensively and within the family context is an effective mechanism for promoting child health and development and for supporting families in their efforts to move out of poverty and to achieve self-sufficiency. It is with this objective in mind that I am pleased to present the first year's findings of the process evaluation on what I consider to be one of the most exciting social services research projects of the 1990's.

Wade Horn, Ph.D.
Commissioner of the Administration on Children, Youth and Families

PREFACE

The Comprehensive Child Development Act of 1988 was enacted because both Congress and the Bush administration recognized that low-income families are becoming increasingly vulnerable in today's society and that human services need to reach these families early enough to be effective. These services must be sufficiently comprehensive and sustained over an adequate period of time to make real and meaningful differences in family members' lives. If delivery of these services is not sufficiently comprehensive and intensive, low-income families can, and often do, feel that they are alone and without adequate supports to contend with increasing pressures and demands.

Human services systems for these families have been criticized historically as categorical, fragmented, and even somewhat disorganized. The focus of these systems has been on achieving singular objectives and serving the needs of some, but not all, family members. Furthermore, the existing public welfare system has been overburdened by severe staff shortages, inadequate resources, and little or no interagency coordination or service integration, making it difficult for family members to access the services that *are* available. The need to examine an alternative approach to traditional human services delivery has never been more apparent or timely. The Comprehensive Child Development Program (CCDP) has been identified as such an alternative approach.

Conceptually, CCDP embodies the values and ideals of the family support community. Specifically, CCDP does the following:

- Involves the whole family and the whole community in program planning and implementation;
- Establishes a system of networks characterized by peer and staff supports;
- Focuses on optimizing child growth and preparing children for later school experiences;
- Prepares parents as significant change agents in their children's development and in their own development;
- Serves as a catalyst for connecting various community and public programs and agencies that deliver specific services;
- Builds upon each family's strengths rather than serving only as a remedy for weaknesses;
- Intervenes early in the life of a child and family and provides continual supports over a sustained period of time; and

- Assists families in meeting goals by working with them to establish relevant and viable paths and a roadmap for progressing along these paths.

At the heart of CCDP is the goal to empower families and family members to better cope with the stresses and anxieties of their daily lives and to achieve goals that are meaningful to them. As Sharon Lynn Kagan suggests, "We should seek to empower the family as its own unit—making it responsive to its own functionings, as well as to the larger community in which they live and exist."

Kagan would be the first to admit that this goal is not easily attainable. High mobility, large bureaucracies, and poor access are just some of the factors that make it difficult for low-income families to develop the intricate community linkages that are essential for mutual support and subsequent growth.

What magic does CCDP possess to turn all of this around?

First, CCDP is foremost a family-focused program. Its premise is that families can be empowered to make a real difference in their lives when they set goals which are meaningful to them and which they believe can be achieved. CCDP provides them with the skills and opportunities to enhance and reinforce this belief.

Second, CCDP capitalizes on available opportunities for support and assistance that already exist in communities. The program pulls together and coordinates relevant community and public resources in a manner designed to enhance the availability and quality of these resources.

Third, CCDP encourages and facilitates the participation of a broader base of resources than is typical of existing human services systems. These resources provide accurate, realistic, and user-friendly information, guidance, encouragement, and emotional support to families to facilitate a greater utilization of needed services.

Finally, and more specifically, CCDP provides greater access to services through improved transportation systems; a case management approach for effectively brokering services between families and service agencies; a child development and parent education and training component for enhancing the individual and joint growth of children and parents; and a local advisory board consisting of parents, service providers, representatives of business enterprises, and community leaders who work together as part of a coordinated network for the empowerment of families.

When Congress wrote the Comprehensive Child Development Act, it crafted a demonstration to determine CCDP's feasibility and cost effectiveness. Congressional intent was for the Department of Health and Human Services to establish an empirical support base for recommending further legislation.

To create a program that encourages both innovation and relevancy in response to the needs of its constituency, the Administration on Children, Youth and Families (ACYF) designed CCDP with the underlying assumption that no single family-support or community-support model can be considered as being the best. ACYF program designers felt that model effectiveness probably would vary among different communities, family structures, and cultures. Consequently, ACYF did not prescribe specific service delivery models and, instead, allowed each project to develop its own models.

Nevertheless, CCDP's 24 grantees are bound together by a set of similar goals. Although differing in terms of the intensity, frequency, and duration of services and service delivery systems, all projects share the requirement to provide or guarantee the provision of the same set of core services for families. Furthermore, although differing in terms of the philosophy and strategy used to enhance the intellectual, social, emotional, and physical development of children, all projects share a common goal for children to reach their optimum growth potential. Lastly, although differing in terms of the characteristics of their parent involvement initiative, all projects share multiple goals for parents to become more effective educators of their children, to move toward economic and social self-sufficiency, to reduce or eliminate parent dependency on drugs, and to promote the healthy birth and care of their infants.

The CCDP demonstration affords a wonderful opportunity to examine how best to strengthen and empower families. This first annual report will provide readers with an excellent understanding of how CCDP intends to accomplish this goal. Enjoy!

Allen N. Smith
ACYF Federal Project Officer

EXECUTIVE SUMMARY

INTRODUCTION AND BACKGROUND

In 1988 Congress enacted the Comprehensive Child Development Act (Public Law [P.L.] 100-297). This Act authorized an innovative effort (1) to provide intensive, comprehensive, integrated, and continuous support services to children from low-income families from birth to entrance into elementary school and (2) to provide needed support services to parents and other household family members to enhance their economic and social self-sufficiency. The Act provided for the establishment of up to 25 Comprehensive Child Development Program (CCDP) projects to be administered by the Administration on Children, Youth and Families (ACYF). ACYF designed CCDP to reflect the ideals of two major programmatic movements in human services delivery and child development that have emerged over the last 20 years. First, CCDP recognizes the crucial role that parents play in their children's development and consequently initiates intervention early in the child's life and works intensively with the entire family to develop an optimal environment for growth and development of all family members. Second, CCDP acknowledges the utility of integrating human service delivery efforts across agencies and programs to increase the effectiveness and efficiency of these programs in serving low-income populations. This report provides descriptive and analytic information about the first 18 months of operation of CCDP.

Background of CCDP

Several early intervention programs led to the development of CCDP. These include Project Head Start, which serves 3- to 5-year-old children from low-income families; Parent Child Centers, a comprehensive program serving families with children from birth to 3 years of age; the Child and Family Resource Program, which provided prenatal care and other services to low-income families with children from birth to 8 years of age; and the "Beethoven Project," a family-centered project in Chicago serving children from before birth through age 5.

Evaluations of these programs suggest that intervention strategies for low-income children and their families have the greatest effect if the strategies: (1) begin at or before birth and continue until entrance into school; (2) are intensive and comprehensive; (3) address all developing domains of the child, including intellectual, social, emotional, and physical development; (4) include all family members as program participants; (5) are firmly grounded in the community in both the planning and implementation stages; (6) coordinate service delivery with agencies already serving the community; (7) utilize state-of-the-art delivery strategies and curricula; and (8) have strong transition procedures from the intervention program to the public schools. CCDP includes all of these components.

The Comprehensive Child Development Act of 1988 was signed into law on April 28, 1988; the Act is authorized for 5 years from Fiscal Year (FY) 1988 to FY 1993 at an annual

authorization level of $25 million.* Twenty-two CCDP projects were funded in 1989, and two additional projects were funded in 1990.**

Requirements of CCDP

The Act mandates that certain core services be provided. For infants and young children, these services include infant and child health care, including screening, immunization, and treatment; licensed child care; early childhood education that is developmentally appropriate; early intervention services for children at risk for developmental delay; and nutrition services. For parents, grantees must provide prenatal care; education in infant and child development, health, nutrition, and parenting; assistance in securing adequate income support, health care, nutritional assistance, and housing; mental health care; vocational training and adult education; and substance abuse education and treatment. In addition, grantees must ensure adequate transportation exists for program participants to access these services. The Act does not intend for grantees to provide all of these services directly but encourages coordination with and utilization of services existing in the community.

The Act also requires that an evaluation be conducted and a report be submitted to Congress on the effects of CCDP. To provide information for the evaluation, the Act requires that each grantee "collect data on groups of individuals and geographic areas served, including types of services to be furnished, estimated cost of providing comprehensive services on an average per user basis, and types of and nature of conditions and needs identified and met."

To ensure an objective evaluation, ACYF separated the feasibility and process evaluation of CCDP from the impact evaluation. The feasibility and process evaluation examines how services are made available and delivered in support of the goals enumerated for CCDP in the legislation. The feasibility and process evaluation is conducted by the management support contractor, CSR, Incorporated, which also provides assistance to ACYF in administering the program and providing technical assistance to grantees by monitoring their activities via the CCDP Management Information System (MIS) and site visits, and by conducting national conferences and regional training workshops. The impact evaluation, conducted by Abt Associates, assesses multiple areas of impact of CCDP on the development of children, parents, and families by comparing the results of outcome measures administered to families in treatment and control groups.

* The Human Services Reauthorization of 1990 extended CCDP to FY 1994 and increased the annual authorization level to $50 million.

** Congress increased the annual appropriations level to $45 million beginning in FY 1992 and requested that additional grantees be funded.

FRAMEWORK FOR THE FEASIBILITY AND PROCESS EVALUATION OF CCDP

The feasibility and process evaluation seeks to address the following overarching research question: To what degree and how are services made available and utilized to address family needs and goals and to promote positive family development? The issue of *feasibility* concerns whether it is possible to establish a CCDP project as intended in the legislation and with what degree of success. The evaluation of feasibility examines the development and structure of CCDP projects—including startup development, the organization of service delivery developed via interagency agreements, the costs of service delivery, and program adaptation over the duration of the project—on the assumption that outcomes will be affected by the availability of resources in communities, the response of community organizations to coordination of services, characteristics of the grantee agencies, the resources projects have at their disposal (e.g., funding, staffing), and the demographic characteristics of the client populations. The *process evaluation* concerns how services actually are provided and utilized by families, including the assessment of family needs and goals attainment, service content, availability of services, and frequency of service use. The process evaluation explores how service utilization is related to the community context in which CCDP projects develop and operate, to the needs and goals of client families, and to the system of operations used by a particular CCDP project.

Both quantitative and qualitative data are used in conducting the feasibility and process evaluation. Quantitative data sources include social indicator data bases such as the 1990 census and the data bases contained in the CCDP MIS. Qualitative data sources include projects' proposals, quarterly progress reports, action plans, reports from site visits, and case study reports by project ethnographers.

METHODOLOGY AND FINDINGS

Data from these and other sources were analyzed to develop this report, which addresses a number of management analysis questions regarding CCDP operations during the first 18 months of funding. The findings of this implementation analysis are contained in six broad areas, which are discussed below.

Description of Sites

CCDP projects are located in each of the 10 Department of Health and Human Services (DHHS) regions of the United States. There are 6 rural projects; 4 of these serve 60 families, 1 serves 98 families, and 1 serves 45 families. The 18 urban projects each serve 120 families, except for 1 that serves 160 families and 1 that serves 180 families. Grantee agencies are varied and include six community/family service centers, six colleges/universities, four community action agencies, three health centers/clinics, two child development/day care organizations, one school district, one foundation, and one city administration. Staffing configurations are varied, but all projects have a project director, a data manager, and a number of case managers or home visitors. Most projects have an early

childhood education coordinator and case management supervisor, and many have a staff member who coordinates adult education and training. Each project operates under a grantee agency headed by an executive director.

Characteristics of Enrolled Families

In order to test program effectiveness most accurately, CCDP was established as a demonstration program incorporating an experimental design. Eligible families in each community were recruited and then assigned randomly to program (treatment), comparison (control), and replacement groups. Projects enrolled families that were representative of the demographic composition of their communities in terms of race/ethnicity and percentage of teenage parents and that met the following three eligibility criteria: (1) the family's annual income was below the 1989 Federal poverty guidelines, (2) the family included an unborn child or child under 1 year of age, and (3) the family agreed to participate in CCDP activities for 5 years. Twenty-three projects were successful in enrolling a total of 2,549 families in the program group by the end of calendar year 1990. Of these 2,549, 44 percent were black, non-Hispanic; 27 percent were Hispanic; 24 percent were white, non-Hispanic; 4 percent were American Indian or Alaska Native; and 1 percent were Asian/Pacific Islander. Although family compositions varied, 37 percent of families had a father living in the household, and the average household size was 3.7 family members. Program families included a total of 4,158 children under the age of 5, the majority of whom were under 1 year of age at the time of recruitment. The children's primary caregiver was between 20 and 25 years of age in 40 percent of families and was an adolescent in 28 percent of families. The average family income at the time of recruitment was $5,707.

Program Startup and Implementation

During the startup period, the CCDP projects had to establish themselves as new organizations, which included both assembling the requisite facilities, equipment, staff, and clients and acquainting the community with the goals and purposes of CCDP and the new project.

Interagency Coordination

To encourage coordination with other community agencies, each project established an advisory panel comprised of project staff, staff from other service delivery agencies, business community representatives, and client families. Additionally, projects established interagency contracts or agreements with other community agencies to facilitate coordination of service delivery and to avoid duplication and gaps in services. Twenty-two grantees developed 200 agreements, 65 percent of which were *cooperative* agreements, i.e., formal written agreements containing information about the services to be provided, tasks to be performed by both agencies, and the duration of these tasks; fees were not involved in these agreements. Twenty-eight percent of the agreements were *contractual* agreements that involved a formal written document outlining provisions made by both parties and the fees to be rendered for these services. Finally, 8 percent of the agreements were unwritten *referral* arrangements,

which allowed projects to refer clients to a particular agency. Among the agreements analyzed, 34 percent were in the area of health, 24 percent involved education and training, 22 percent focused on services for children such as child care, 10 percent were for social services, and 9 percent were for services to assist with administration and staff training.

Startup Issues

Over half of the projects had difficulty recruiting the targeted number of families to be served by the September 1990 deadline for complete enrollment. Although a spectrum of recruitment methods was utilized, the key factor in successful recruiting seemed to be personal contact with potential participants. Locating, renovating, and licensing space for offices and child development facilities presented a challenge for nearly 60 percent of the projects. Although most projects had secured permanent space by the end of the first year, the staff at some projects experienced several moves during the year and sometimes were located in crowded or makeshift facilities. Hiring a qualified staff proved difficult for 59 percent of the projects. Qualified candidates may have been deterred from applying for and accepting positions with CCDP projects because job descriptions were somewhat amorphous or unfamiliar, the client families were very poor and had many problems, and the communities to be served were low income and often dangerous. As might be expected in a new human service program, there was a considerable degree of staff turnover. In the first year, more than one-half (54 percent) of the projects lost four or more staff members, and 27 percent of the projects lost project directors. Overall, staff attrition was 18 percent. Many projects had underestimated the scope and complexity of activities that would be required to create a workable team of staff members to provide the mandated services. Projects discovered their proposals had not budgeted sufficiently for services such as child care and health care for adults. Finally, projects had to mesh the differing philosophies and preconceptions of program staff regarding how core services should be delivered.

The degree to which projects experienced these difficulties with startup varied between programs. Projects tended to have less difficulty when startup activities were conducted according to a set of goals and timelines that were established during the initial stages of program planning.

Service Delivery Characteristics

Case Management

The use of family-focused case management is a key aspect of CCDP service delivery. Case managers are responsible for building relationships with families and for providing, brokering, coordinating, and/or monitoring the delivery of services that are necessary to carry out a set of goals established by the family. In addition, case managers must collect data regularly on the services family members are receiving. These data are used for the process evaluation and to monitor families' progress in achieving their goals. Of the 22 projects,

21 use a generalist model in which one individual relates to a given family and coordinates all activities of the case management function.

The titles and exact job descriptions of case managers vary from one project to another, but case managers at all projects use a family needs assessment and family service plan to gather information about each family and establish goals and activities to be conducted by each party in order to achieve those goals. There is an average of 7 case managers at each site, and caseload sizes range from 8 to 30, with an average caseload of 16 families per case manager. Among the 12 projects visited during the first year, three-fourths of the case managers were making home visits at least once every 1 or 2 weeks. During the first year, home visits tended to focus on family stabilization, and activities often were geared toward meeting crisis needs such as threat of eviction, lack of food, imminent cutoff of utilities, domestic violence, and acute alcoholism. Case managers found it necessary to address families' most basic needs of food, shelter, and security before they were able to begin focusing on long-term goals such as parent educational or vocational training.

The importance of balancing efforts to meet crisis needs with activities in support of long-term goals became especially apparent for staff members who were called upon both to perform case management activities and to provide child development training and experiences during their regular meetings with families. Case managers at the majority of projects (57 percent) performed both of these functions. At other projects, the early childhood and case management functions were performed by separate persons. The latter approach has several advantages in that it increases families' exposure to project staff and sometimes lends greater clarity to task assignments, but it also requires a high level of communication and coordination between the various staff members working with a given family. Consequently, projects have placed an emphasis on creating teams for supervising and coordinating work with families to ensure that tasks are performed in the most efficacious manner.

Discussion of Core Services

All children under school age must receive a developmental screening and assessment, and children who are found to be delayed in any area receive early intervention services. The tools most frequently used by the 22 projects in screening children are the *Denver Developmental Screening Test II* and the *Hawaii Early Learning Profile Instrument.* Children also must be provided with an appropriate early childhood experience in a center, in the home, or by a combination of home- and center-based activity. Most of the 22 projects provide children with this experience either through a CCDP center, through a Head Start program, or in a family home. The most frequently used curricula in these programs are the *Hawaii Early Learning Curriculum*, *High Scope*, and *Small Wonder*.

Child care must be provided to families when requested by a parent who is working or involved in training. Projects initially encountered difficulties in meeting the child care needs due to inadequate budgeting for the cost and number of children who would be receiving child care early in the program and due to the lack of child care slots and appropriate

facilities for adequate care. Projects addressed the problem by developing innovative mechanisms for affordable child care, such as training and defraying costs for families interested in becoming family day care providers, negotiating contracts to purchase a large number of slots at a lower than normal rate or negotiating contracts with additional agencies, and aggressively pursuing grants for the improvement of local child care arrangements. Several projects developed onsite child care centers.

All projects have developed linkages with clinics or medical centers to provide routine health care for CCDP clients. These health providers usually are located in close proximity to the families they serve; in some cases, a project and a coordinating health agency have arranged to be located in the same facility to allow families to take advantage of multiple services during a single visit to the site. One-half of the projects also have linkages with private physicians to maintain continuity of care. Twelve projects have a health specialist such as a doctor, nurse, or medical director on their staff, and five projects have designated staff members who provide some health services during home visits. Four of these five are rural projects and find this arrangement often alleviates the need to transport families long distances to receive routine or preventive care. All projects have agreements with hospitals or local public health departments to ensure children receive acute health care when necessary.

Mental health support, including individual and family therapy, marital counseling, and treatment for aberrant or dysfunctional behavior, usually is provided through linkages with local mental health centers or private mental health agencies. Three projects provide mental health support directly through the program. Similarly, most projects provide substance abuse treatment services through agreements with drug and alcohol treatment centers, health centers, and alcohol rehabilitation centers. Three projects use staff nurses to provide substance abuse counseling onsite but refer family members to more specialized facilities for more indepth counseling and treatment.

The CCDP parent education component includes instruction in child development, childrearing, and health care as well as nutrition counseling. Most parent education is provided one-on-one with the family during home visits. Parent education also occurs in group settings scheduled regularly at project facilities or other community agencies. Health care providers also provide education during regular visits by the family. Projects provide for a wide array of adult education and vocational training programs to assist families in meeting their economic and self-sufficiency goals. Training in literacy, basic skills, skills for daily living, and English as a Second Language (ESL) usually are provided through referral arrangements with community colleges and local educational institutions that already are serving the community. Four projects, however, provide adult education onsite. Similarly, most projects provide for vocational training through interagency agreements with and referrals to local community colleges, high schools, vocational centers, State employment and training facilities, departments of social services, and Job Training Partnership Act (JTPA) grantees. One project provides vocational training services directly through the program. Grantees are pursuing linkages with the business community to identify employment opportunities for CCDP families.

To ensure all CCDP families are receiving the income support and other benefits to which they are entitled (e.g., AFDC, Medicaid, food stamps), projects have formalized relationships with the State departments administering those services and frequently act as advocates for the families within those departments when special attention is required. To ensure that families have access to all CCDP core services, projects have developed various means of transportation—including providing bus tokens, purchasing vans and hiring drivers, and/or hiring cabs—to supplement existing systems whenever necessary.

Attrition

Attrition figures are based on the number of families who were lost, refused participation, or were dropped between the time they were originally notified of assignment to the program or comparison group and the time of enrollment. Of 2,329 families recruited and assigned to the program group at 22 projects, 8.9 percent were lost or dropped, and 5.5 percent refused participation. Of the 2,329 assigned to the comparison group, 8.5 percent were lost or dropped, and 4.2 percent refused to participate. The highest rate of attrition for program families at any project was 56 percent, and the highest rate for comparison families was 51.7 percent. Five projects had no initial attrition for the program group, and seven projects had no initial attrition for the comparison group.

Site Visit Findings

Twelve grantee sites that had been in operation between 9 and 14 months were visited. Post site visit letters and site visit reports were reviewed to examine issues dealing with CCDP program administration, core services for children and adults, case management, and administration of the MIS. Areas noted as strengths or programmatic issues in 6 or more of the 12 sites visited are discussed in this report.

Strengths

Despite the initial difficulties in recruiting staff, site visitors found that all projects had developed a core of qualified staff members who were committed to the program and its families. All MIS hardware and software were in place at seven of the projects, and six projects had reached their recruitment goals by the date of their site visit. Case managers at eight projects were commended for their excellent rapport with client families. Although projects had experienced difficulties arranging a sufficient number of child care slots, six projects were commended on the quality of child care facilities they had selected. These facilities provided a safe environment, well-qualified staff, and good care, including the provision of developmentally appropriate activities in several programs. Seven projects had established strong programs for routine and preventive health care for children, and five of these also had a well-defined program for the provision of acute care services to children. Nine programs had established good mechanisms for the provision of prenatal care. A supportive relationship between the grantee/umbrella agency and the CCDP project was cited as a strength for six projects.

Programmatic Issues

Although projects accomplished many tasks quickly and with great success, the completion of a number of other tasks—including delivery of some core services—posed difficulties for projects visited during the startup period. Following the site visits, however, the 12 projects quickly took steps to address the issues identified and remove obstacles to service delivery.

By the date of their site visits, seven projects had not completed developmental screenings for all preschool children; five of these seven, however, had successfully completed all screenings by the end of the startup year, and two projects had completed most screenings. Eight projects had not completed individual developmental plans for children as of the site visit, and 11 projects had not implemented an appropriate early childhood curriculum during home visits. By the end of the startup period, most projects had completed individual developmental plans for all preschool children, and all 12 projects had adopted an appropriate early childhood curriculum. Six projects were not providing developmentally appropriate early childhood developmental experiences either through home- or center-based programs; four projects had resolved this issue by the end of the startup year. Nine of the twelve projects had inadequate provisions for child care. Six of these projects had made acceptable temporary arrangements for the provision of child care by the end of the startup year; however, this issue will continue to be of concern as the need for care increases with time.

Because case managers tended to focus initially on crisis-oriented work, it is not surprising that family needs assessments and family service plans had not been completed for all families at 9 of 12 projects visited. By the end of the startup year, all projects had completed needs assessments and service plans for all families, usually by developing an organized and systematic recordkeeping system for managing caseloads that would be monitored and reviewed on an ongoing basis. Case managers at eight projects were unclear about which services were available through CCDP and who was responsible to pay for these services; case managers at six projects were unsure of how to access some services offered through the program. Projects addressed these issues by providing staff training when needed and, in some cases, by developing "menus" or directories of services available and how to access them.

A majority of projects were not providing adequate parenting education in infant and child development, health care, and nutrition when visited. Most had resolved this issue by the end of the startup year, for example, by designating or hiring staff to coordinate that component or by reviewing agreements with other agencies to ensure services were being provided as specified. Finally, projects had convened advisory panels to provide guidance for the program. The advisory panels for eight projects, however, lacked representation from the business community, and the panels for six projects lacked representation from client families. Projects addressed these issues through aggressive recruiting of appropriate business community members and by establishing mechanisms by which parent representatives to the

panel would be selected initially and throughout the project. All projects had resolved the issues of appropriate representation on advisory panels by the end of the startup period.

FACILITATORS TO STARTUP AND EARLY SUCCESSES

Examination of those projects that performed well in implementing startup tasks revealed several characteristics that distinguished them from projects that had more problems. The presence of a strong management team was an important indicator of a successful startup. Strong management generally was able to establish goals early and use critical management skills to juggle all activities necessary to meet those goals in a timely fashion. Projects that phased in their program operations and startup tasks had greater success than those that attempted to undertake too many activities simultaneously. Projects serving a smaller number of target families also experienced less difficulty with startup. Projects that were best able to implement their programs exhibited clear lines of staff supervision, including in some cases midlevel managers to coordinate direct service staff. Successful programs had qualified staff members to cover key positions rather than having positions remain vacant for long periods. A supportive relationship between the grantee agency and the CCDP project and a positive reputation of the grantee agency in the community also contributed to a smoother startup for some projects. Ready access to community resources also was found to be a facilitator of implementation. Finally, projects not located in an inner-city environment with problems of lack of housing, drugs, crime, and unemployment experienced fewer startup problems.

The first year of CCDP was a challenging one for the projects. Establishing a new multiservice program with few precedents and incorporating requirements for the experimental design, the MIS, and Federal mandates was a demanding and complex task. Despite difficulties in completing startup tasks and initiating service delivery, projects were beginning to impact upon the lives of the families being served. Many families expressed to staff members, ethnographers, site visitors, and Government officials their enthusiasm for the program and gratitude for the difference it has made already in their lives and the lives of their children.

CHAPTER 1: THE COMPREHENSIVE CHILD DEVELOPMENT PROGRAM (CCDP): INTRODUCTION AND BACKGROUND

INTRODUCTION

In 1988 Congress enacted the Comprehensive Child Development Act (Public Law [P.L.] 100-297). This program is an effort (1) to provide intensive, comprehensive, integrated, and continuous support services to children from low-income families from birth to entrance into elementary school to enhance their intellectual, social, and physical development and (2) to provide needed support services to parents and other household family members to enhance their economic and social self-sufficiency. The underlying philosophy of the Act is that children are an integral part of the larger family unit and that this unit must be served in a comprehensive and integrated manner if the cycle of poverty in which these families are entrenched is to be broken. P.L. 100-297 also mandated that programs funded collect data on groups of individuals and geographic areas served, including types of services to be furnished, estimated costs of providing comprehensive services on an average per user basis, types and nature of conditions and needs identified and met, and such other information that the Secretary of the Department of Health and Human Services (DHHS) may later require.

In 1989 and 1990 DHHS funded a total of 24 Comprehensive Child Development Program (CCDP) grantees to serve more than 2,500 families. The first 18 months of funding were exciting and challenging ones for the projects. During this time the projects hired and trained staff members, located and renovated facilities, developed and refined intervention approaches and models, formed advisory boards, negotiated service agreements, recruited and enrolled families, and began providing services.

This report provides descriptive and analytic information on the first 18 months of CCDP operations. It also includes a historical review of the development of CCDP and the status of the two third-party contracts to support and evaluate the program. Findings about the projects and families served are presented in the text of the report including information about key program components across projects, plus barriers and facilitators to start-up and implementation. In the Appendix are profiles of each of the projects summarizing key characteristics.

HISTORY OF CCDP

CCDP is an innovative effort put forth by the Administration for Children, Youth and Families (ACYF). The design of CCDP is based on an extensive history of research and programmatic efforts in early intervention programs for children, and the legislation enacting CCDP reflects the successful components of these efforts. The early intervention programs that led to the design of CCDP, the components of the program, and the process by which CCDP came into existence are discussed below.

Early Intervention Programs That Led to the Development of CCDP

Many of the Nation's early intervention programs for children have been funded and conducted under the auspices of the Federal Government, first through the Office of Child Development (OCD) and later through ACYF. The largest and most well known of these intervention programs is Project Head Start, a program which began in 1965 as part of the War on Poverty and which has been a progenitor of numerous demonstration and experimental programs. Project Head Start serves 3- to 5-year-old children from low-income families and their parents. Head Start is, and was from its conception, a comprehensive program intended to involve parents actively and to address all aspects of children's lives, including their physical and emotional health and their social and intellectual development. It was recognized by many child development specialists, however, that intervention should begin earlier in a child's life, because deterioration of cognitive and emotional functioning can begin even in the first month of life (Greenspan, 1981).

In response to these concerns, the Head Start program was expanded in 1967 to include comprehensive early intervention programs called Parent Child Centers (PCC's) for children from birth to 3 years of age. PCC's were designed to enhance the development of children and to strengthen parents as primary educators by providing low-income families with social services and health and educational assistance. PCC's provide educational services to children 2 or 3 days per week either through center-based programs, home-visiting activities, or a combination of both.

From 1973 through 1978, the Head Start Bureau of ACYF funded a demonstration project entitled the Child and Family Resource Program (CFRP), which provided services to low-income families with children from before birth to 8 years of age. As a family-oriented child development program, it provided continuity through the child's early years by offering three components: (1) an infant-toddler component (prenatal through age 3), (2) Head Start (age 3 through 5 years), and (3) a preschool linkage component for children making the transition from preschool to elementary school. CFRP emphasized comprehensive assessments, individualized planning, and reassessment for identifying families' needs and providing services to meet those needs.

The last program that is significant to the development of CCDP is the Center for Successful Child Development (CSCD), also known as the Beethoven Project. The project began in 1986 under funding from the Harris Foundation. CSCD is located in the Robert Taylor Homes housing project in Chicago and represents a model for community-based prevention and early intervention services. The main goals of CSCD are to promote the healthy growth and development of children from before birth through age five and to prepare them for achievement in the public school. CSCD uses two basic strategies for achieving these goals: gaining the early and continued participation of the community in the planning and delivery of services and using a family-centered rather than a child-centered approach.

The programs described above have generated a host of research and evaluative efforts that have assessed the effectiveness of early intervention programs. Although persistent

difficulties have been encountered in obtaining evidence of intervention program effects (due in part to the diversity of programs), a vast amount of literature suggests that these intervention programs are a viable means of promoting child development, fostering parenting skills, and enhancing family self-sufficiency. In addition, the research indicates that intervention strategies for low-income children and their families have the greatest effects if programs: (1) begin at or before birth and continue until entrance into school; (2) are intensive and comprehensive; (3) address all developing domains of the child, including intellectual, social, emotional, and physical development; (4) include all family members as program participants; (5) are firmly grounded in the community in both the planning and implementation stages; (6) coordinate delivery of services with agencies and institutions already serving the community; (7) utilize state-of-the-art delivery strategies and curricula; and (8) have strong transition procedures from the intervention program to the public schools. All of these components are incorporated into CCDP.

Establishment of CCDP

On July 22, 1987, the Committee on Labor and Human Resources brought before the full Senate a bill that amended the Head Start Act by providing for the establishment of several comprehensive child development centers that would provide intensive and comprehensive services to children and families living in poverty. The bill was sponsored by Senator Edward Kennedy, Chairman of the Committee, and was cosponsored by Senators Matsunaga, Simon, Dodd, Harken, Adams, Weicker, Stafford, Mikulski, Pell, Metzenbaum, and Bingaman. The bill was approved unanimously by the full Senate, and on April 28, 1988, the President signed into law the Comprehensive Child Development Act of 1988 (Part E of P.L. 100-297). This Act is authorized for 5 years from Fiscal Year (FY) 1988 to (FY) 1993 at an annual authorization level of $25 million.[1]

The Act provides for the establishment of at least 10 but not more than 25 CCDP projects.[2] According to the law, a wide range of agencies were eligible to establish these programs, including the following: (1) Head Start agencies, (2) community-based organizations, (3) institutions of higher education, (4) public hospitals, (5) community development corporations, or (6) any public or private nonprofit agency or organization specializing in the delivery of social services to infants and young children. On December 29, 1988, a Federal Register announcement was issued to call for proposals to establish CCDP projects. The Federal Register announcement defined program requirements in greater detail—including the specification of core services to be provided—and gave application procedures. To assist new, small, or economically disadvantaged agencies in applying for grants, the Act made available funds for up to 30 planning grants. DHHS issued 30 planning grants for a 3-month period and subsequently received 211 applications for

[1] The Human Services Reauthorization of 1990 extended CCDP to FY 1994 and increased the annual authorization level to $50 million.

[2] Congress increased the annual appropriations level to $45 million beginning in FY 1992 and requested that additional grantees be funded.

operational grant funds to establish CCDP projects. After a very competitive assessment process to identify those agencies with the best potential for working with community groups in delivering services to young children and their families, 22 agencies were funded in 1989, and two additional agencies were funded in 1990. The 24 CCDP projects funded are listed below.

Project AFRIC
Dimock Community Health Center
Roxbury, MA

Windham County Family Support Project
Brattleboro Town School District
Brattleboro, VT

Project CHANCE
Project Teen Aid
Brooklyn, NY

Parent-Child Resource Center
Edward C. Mazique Parent Child Center
Washington, DC

Family Start
Friends of the Family, Inc.
Baltimore, MD

Family Foundations
Community Human Services
University of Pittsburgh
Pittsburgh, PA

Toddlers, Infants, Preschoolers, and Parents (T.I.P.P.)
Dade County Community Action Agency
Miami, FL

Operation Family
Community Action Council of Lexington-Fayette, Bourbon, and Nicholas Counties
Lexington, KY

Tennessee CAREs
Bureau of Educational Research and Services
Tennessee State University
Nashville, TN

Project Focus
Grand Rapids Child Guidance Clinic
Grand Rapids, MI

West CAP Full Circle Project
Western Wisconsin Community Action Agency
Glenwood City, WI

Project Family
Arkansas Children's Hospital
College Station, AR

Families in Partnership CCDP
City of Albuquerque
Albuquerque, NM

Primero Los Niños
La Clínica de Familia
Las Cruces, NM

Avance CCDP
Avance, Inc.
San Antonio, TX

ShareCare Program
Day Care Association of Fort Worth and Tarrant County
Ft. Worth, TX

Comprehensive Child Development Program
Mid-Iowa Community Action
Marshalltown, IA

Project EAGLE
University of Kansas Medical Center
Kansas City, KS

Family Futures
Clayton Foundation and Mile High Child Care
Denver, CO

Comprehensive Child Development Program
Little Hoop Community College
Fort Totten, ND

Community-Family Partnership Project
Center for Persons With Disabilities
Utah State University
Logan, UT

Conocimiento
Southwest Human Development, Inc.
Phoenix, AZ

ENRICH
Venice Family Clinic
Venice, CA

Families First
Children's Home Society of Washington
Auburn, WA

The 18 months following initial funding were designated as a startup period for the program, during which time grantees were to hire and train all project staff, obtain facilities, acquaint the community with the goals and purposes of CCDP, negotiate interagency agreements to provide contractual services, recruit all families, and begin to deliver services. In actuality, the startup period stretched to about 20 months for many projects that were not fully implemented by the end of 1990.

Objectives and Components of CCDP

The legislative goals of CCDP are threefold and include (1) preventing educational failure by addressing the psychological, medical, institutional, and social needs of infants and young children; (2) decreasing the likelihood that young children will be caught in the cycle of poverty; and (3) preventing welfare dependency and promoting self-sufficiency and educational achievement (U.S. Congress, 1987).

Although the Act does not define a particular service delivery system to which grantees must adhere, it does mandate that certain core services be provided, at a minimum specified level, in order to enhance the intellectual, physical, and emotional development of children. All contacts and services, whether provided by CCDP or another agency, must be recorded and entered into the Management Information System.

The core services embodied in the Act and further clarified in the December 29, 1988, Federal Register announcement and subsequent administrative program instructions are:

Early Childhood Development/Early Intervention/Child Care

- Developmental screenings and assessments must be completed by the project or another agency for all children under compulsory school age in the program family.

- Based on the findings of the screening and assessment, an individual development plan must be written for all children under school age in the family.

- Children who are at-risk/developmentally delayed must have timely access to an intervention program.

- Each program must identify an appropriate developmental curriculum/curricula and adequately train those staff members who will be implementing the curriculum.

- An adequately intensive child development experience must be provided for all children under school age. If the parent is directly involved in the early childhood activities being provided to the child whether in a home or in a center, that is, if the early childhood experiences are parent-focused, they must be provided at least once a week. (It is assumed that if parents are involved in providing the early childhood experiences, they will be able to repeat the activities during the rest of the week.) If the parent is **not** directly involved, that is, if the child is in a center or full-time care and the teacher is providing the early childhood experiences, they must be provided at least three times a week.

- Child care must be available and accessible to any parent requesting it when the primary caregiver(s) is/are in training or working.

- Child care centers, family day care homes, and child development centers must meet State licensing standards or certification. If the center also is providing the child's early childhood educational experience, the center also must meet relevant Head Start Performance Standards, including:

  — Baselines for adult-child ratios/group size;

  — Daily/weekly schedules;

  — Developmentally appropriate toys/equipment/curricula;

  — Culturally relevant materials/staff;

  — Training for staff on utilizing a developmentally appropriate curriculum; and

— A documented mechanism to ensure that activities in center-based care or care in family day care homes will interface with developmental activities provided at home.

Parent Education And Training

- Training must be provided to parents in infant and child development, health care, nutrition, parenting skills, and life skills/functioning (e.g., budgeting). This training may be provided through CCDP center-based or home visit training or through a contracting/interagency agreement if the training is accessible to parents and procedures have been established to monitor the training.

- Adult literacy education, vocational training, employment counseling, and job training/placement must be available to all program families requesting those services. Services arranged through contracting agencies must be accessible and provided in a timely manner.

- Linkages with major employers/agencies for jobs for family members are to be established.

- Adult group activities that provide for mutual support are to be available to program parents.

- Specific efforts to increase male participation/involve males in the program are to be made.

Case Management

- Family Needs Assessments must be developed.

- Family Service Plans must be developed. A plan for each eligible family must be included in the Family Service Plan. Services should be closely related to assessed needs.

- Case managers must *broker* services for families.

- Families must receive assistance with nutritional services.

- Families must receive assistance with social services, including housing and income support.

- Emergency resources must be available for families needing one-time assistance for a specific service, activity, or purchase.

- Case managers and families must be aware of all the required core services, and case managers must know how to access these services.

Health

- All families must have access to health care.
- All health care provided should be monitored and documented.

Children

- Health screenings and a comprehensive health assessment for children must be completed.
- Immunizations appropriate for the child's age must be provided.
- Well baby and routine health care must be provided as needed.
- Acute health care must be provided when needed.
- Dental health care must be provided when needed.
- Mental health care must be provided when needed.
- Nutritional services must be regularly provided.

Adults

- Prenatal and postpartum care must be provided as needed.
- Routine and acute health care must be provided as needed.
- Mental health care must be provided as needed.
- Substance abuse education and treatment must be provided when needed.

The following additional requirements must be met:

- Programs must provide adequate transportation to ensure that all families are able to access core services.
- Families must not pay for any core service.[3]

[3] As of date of print, a sliding fee scale schedule for health care and child care, based on family affordability, is being prepared.

The Act does not intend for grantees to provide all of these services directly, unless they are unavailable or unacceptable, but rather it encourages coordination with and utilization of existing community services. Projects must have written, signed interagency agreements describing services to be provided by cooperating agencies. This provision is enhanced by the requirement that each grantee must have an advisory board consisting of program families, individuals with expertise in providing the services offered by CCDP, and community representatives.

In sum, the objectives of CCDP require that local projects both organize the array of human services existent in the community to benefit program families and develop those services the project must provide itself. Each project must build collaborative relationships with other community service agencies to form an integrated service system for program families. The types of interagency arrangements and agreements made by local projects are discussed in a later section.

EVALUATING THE IMPLEMENTATION AND OUTCOMES OF CCDP

The Act requires that an evaluation be conducted and that a report be submitted to Congress on the effects of CCDP along with recommendations for future program implementation. ACYF chose to select third-party contractors to assist in the management and evaluation of CCDP. ACYF also decided to separate the management support and process evaluation of CCDP from the impact evaluation to ensure that the program was evaluated objectively. Thus, ACYF issued two Requests for Proposals—one to conduct the feasibility and process evaluation and provide management support for CCDP and the other to conduct the impact evaluation of the effects of CCDP on children and families. ACYF competitively selected CSR, Incorporated, and its subcontractor Information Technology International (ITI), as the management support and feasibility/process evaluation contractor and Abt Associates as the impact evaluation contractor.

Feasibility and Process Evaluation

The feasibility and process evaluation addresses two broad areas regarding the implementation of CCDP. The first area concerns issues in the development and structure of CCDP projects that relate to feasibility. These issues include startup development, the organization of service delivery developed via interagency relationships, the costs of service delivery, and program adaptation over the duration of the project. The second area concerns issues that relate to the service utilization process, including family needs and goal attainment, service content, availability of services and frequency of use, and the organization of the CCDP project. Although issues of feasibility and service utilization are related, they are distinct focuses for analysis in the process evaluation.

The primary sources of data for the feasibility and process evaluation are the automated MIS, information from site visits, quarterly progress reports, and reports from site ethnographers. The MIS provides, in part, data on service utilization. The site visits provide

information on the status of program implementation at annual intervals. Each project also has a site ethnographer who provides a detailed case study of the project, describing features in the community, service network, the CCDP project, and families that relate to program feasibility and service utilization.

Management Support

The management support contract is designed to provide administrative and technical support to ensure that individual CCDP projects are operated in a manner consistent with the legislative intent and to provide data on the feasibility of implementing and administering CCDP. Given the size, complexity, and duration of CCDP, management of the program requires that ACYF be kept regularly informed of program activities, services, costs, and family characteristics. To meet this demand, the management support contract was designed to provide ACYF with assistance in three broad areas: (1) developing a management information system, (2) conducting on-site visits to each grantee during each funded year, and (3) planning and conducting CCDP conferences.

Developing an MIS

One of the major tasks of the first year was the design and implementation of the automated MIS. The CCDP MIS is a comprehensive, integrated system for organizing and manipulating required data. The system operates on personal computers using a relational data base. The MIS provides project staff with the ability to enter, edit, and report all Family, Health, Education, and Administrative information required by Congress and by ACYF to administer CCDP activities. The MIS serves as a data collection system to meet requirements specified in the law, as a monitoring tool for ACYF to assess grantees' progress in serving families and complying with programmatic requirements, and as a management tool for local projects to monitor operations and expenditures. The MIS was developed to provide the data to respond to congressionally mandated data requirements as specified in P.L. 100-297 and to answer a series of Management Analysis Questions (see Table 1 on the following page). The need for these data was stated in the December 29, 1988, *Federal Register*, and a supplement to this announcement stated that grantees would be required to use an MIS. The MIS would record data on "families, programs' collaborative arrangements, on-going services and costs."

The developmental process for the MIS was a thorough one, involving grantee input from the beginning. MIS forms were revised extensively to accommodate grantees' comments and concerns about form content, the feasibility of obtaining the information, the burden involved in form completion and the information that would be useful to grantees for their own purposes. Field tests of the MIS data collection forms were conducted at four sites. The field tests resulted in an improvement in the precision and utility of the forms and data definitions.

In tandem with the development of the MIS, the CCDP Electronic Bulletin Board (BB) was developed. The BB is an online computer network of the 24 CCDP grantees which

Table 1
CCDP Management Analysis Questions

1. a. What planning strategies are being used in implementing a CCDP model?
   b. How long is needed for a program to become fully operational?
   c. What are the barriers to and facilitators of program start-up?
   d. How long is needed to achieve stability in providing core services to enrolled families?

2. a. What are the characteristics of the various coordination/collaboration arrangements used by grantees?
   b. How are CCDPs linked with other service providers?
   c. Is there duplication of services?
   d. What is the relationship between available services and the proximity of enrolled families?

3. a. What are the characteristics of enrolled families?
   b. How does it compare with the characteristics of poverty families in the community?

4. a. Which non-CCDP-sponsored services are enrolled children and families receiving?
   b. Which CCDP-sponsored services (health, social, educational, child care, etc.) are enrolled children and families being provided and utilizing?
   c. Are they receiving all the core services required by this program?
   d. Describe the duration and frequency of such services by type.
   e. Are these services compatible to the different assessed needs of children and parents?
   f. How are the needs of enrolled families assessed?

5. a. Which educational models are being used?
   b. Are children receiving educational activities which are developmentally appropriate?
   c. Describe classroom and staff characteristics.

6. Describe the characteristics of program models, service delivery systems, and coordination arrangements over time.

7. a. Describe the extent of fanily participation and services utilization in the program.
   b. Describe the degree and type of activity.
   c. Does this activity vary by characteristics of the families, such as SES, number of children, ages of children, family structure, etc.?
   d. Does it vary by characteristics of the program?

8. Describe whether services are consistent with Federal, State, or local standards, including Head Start Performance Standards.

9. a. Describe the costs (CCDP money and non-CCDP money) of providing services by category, family, family member, program model, auspice.
   b. Compare with costs of other services families would be (still are) receiving.
   c. How do these costs vary as a function of the specific coordination/collaboration arrangement?

10. a. What is the attrition rate of enrolled families?
    b. Does it vary by family characteristics?
    c. Why do families leave?

11. a. What are the characteristics of replacement families?
    b. How do they compare with families they replace?

12. What are the barriers projects experienced in program implementation?

allows the projects to communicate with the management and technical support contractor and with each other via electronic mail. BB help and message screens identify resources and distribute directives and up-to-date information about CCDP conferences, site visits, and the MIS.

Data are recorded for the MIS on the program level and individual family member level. All services received by family members are documented in the system. A sequential format enables the assessment of family needs, service plan, goal attainment, and utilization of the services to assist in meeting goals. The following information modules are contained in the system.

- Project Profile
- Project Budget
- Quarterly Expenditures
- Services Location Profile
  - Services
  - Staff
  - Licensed Facility Description
- Area Demographics
- Recruitment
- Family Profile
- Volunteer Participation
- Adult Educational/Vocational Program Description
- Adult Educational/Vocational Course Description
- Adult Educational/Vocational Course Attendance
- Child Educational Program Description
- Home Visiting Program Description
- Child Educational Program Attendance
- Developmental Screening and Assessment
- Family Assessment
- Family Services Plan
- Family Services Contact Summary
- Medical Services
- Pregnancy Description
- Birth Record
- Death Record

Because the MIS collects individual data on program participants, the system had to be approved by the U.S. Office of Management and Budget (OMB). The MIS was submitted for approval in June 1990. Approval was received in late April 1991. Thus, use of the MIS was limited during the first program year. (See Appendix I, page A-1 for more detail about the MIS and the Bulletin Board.)

Cost Analysis System

In addition to using the MIS as a data source and a tool for managing and monitoring the progress being made by grantees, a cost analysis system was developed for CCDP by CSR's subcontractor Bowers and Associates to collect information about costs of services provided to family members. Data for the cost analysis will be drawn from the MIS and time allocation studies in which project staff members keep records of the time they spend on various activities, including service provision. The MIS will contain project budget information, quarterly expenditures, and projects' definitions of service "units." The MIS also will contain the unit costs for services provided through interagency contracts and agreements. Time allocation studies will determine CCDP staff costs for different service areas. The cost analysis will identify service costs by recipient as well as variations in costs associated with different project arrangements for coordinating and providing services.

Conducting Site Visits

Each grantee is visited at least once a year for 3 days by a site visit team comprised of the Federal Project Officer and CSR and ITI staff members. The purposes of these visits are to monitor program compliance, to collect data for the process evaluation, and to provide technical assistance on programmatic and MIS issues. The site visit team reviews all written documentation on the project prior to the visit. During the visit, individual interviews are conducted with senior program staff and representatives of key cooperating agencies; focus groups are held with case managers and with parents; and observations of child care/child development programs, advisory board meetings, home visits, and parent education activities are conducted. The operation of the MIS is reviewed as are administrative and programmatic records. At the conclusion of the visit, a debriefing is held to identify program strengths, weaknesses, and needs for technical assistance.

Conducting CCDP Conferences

Three conferences were held during the first year to provide an opportunity for grantees to meet with the Federal Project Officer, network, and receive training in programmatic issues of relevance to CCDP operations. Invited speakers presented general sessions and workshops on a variety of programmatic topics.

A more indepth discussion of the management support activities is provided in Appendix I.

Impact Evaluation

The impact evaluation to be conducted by Abt Associates will assess multiple areas of impact of CCDP on the development of children, parents, and families. In addition, the impact evaluation will examine mediating factors that help to explain variation in CCDP outcomes for different families and different projects. Data for the impact evaluation will be gathered through a variety of data collection methods, including measures on the quantity and quality of program services received by families and a battery of outcome measures on program and comparison children, parents, and families (Abt Associates, 1991).

* * * * *

This report summarizes startup and implementation issues the projects faced during the first 18 months and describes their structures and the families they serve. Because the MIS was not fully implemented during the first year, only limited data are available from it. However, quarterly reports, the first two ethnographer reports and site visit reports on the first 12 projects visited provide qualitative data.

The next chapter describes the methodology for the feasibility and process evaluation and includes sources of data and information used in other chapters in the report.

CHAPTER 2: FRAMEWORK FOR THE CCDP FEASIBILITY AND PROCESS EVALUATION

INTRODUCTION

The implementation of a Comprehensive Child Development Program has been a complex undertaking. Many features of the program combine to make implementation both very difficult and challenging. Such features are: the number, level, and comprehensiveness of services to be provided; the absence of existing community models for delivery of comprehensive services; the extensive needs of program families; the limitations of community human service resources; and the absence of integrated service delivery networks. To provide information relevant to future policy and programs, ACYF chose to carefully study the feasibility of CCDP implementation and analyze the process of ongoing activities. That is, ACYF chose to examine whether and how these programs can be successfully implemented to meet the goals of the program and the needs of the families.

Although local CCDP projects use varying service delivery systems and service integration arrangements to provide services, all CCDP projects have the following common goals:

- To enhance development and stability of the family through family empowerment;
- To enable economic and social self-sufficiency; and
- To optimize early childhood development.

These goals frame the overarching research question for a feasibility and process evaluation of CCDP: To what degree and how are services made available and utilized to address family needs and goals and to promote positive family development? To answer this question requires understanding of (1) the development of CCDP projects, and (2) the means of service provision and use within and across sites to meet family needs. This focus involves both (1) discerning contingencies that affect the feasibility of developing a coordinated, family-based service program and (2) identifying and studying those contingencies in addition to the family characteristics and needs that affect service utilization.

The issue of **feasibility** concerns the **success of the effort of setting up a coordinated service system at the local level that makes comprehensive human services available and accessible to families.** That is, the issue is to ascertain if it is possible to establish a CCDP project as originally intended. The answer to this question involves studying issues in program startup, the organization of service delivery developed through interagency agreements, the costs of service delivery, and program adaptation over the course of the demonstration.

The issue of **process evaluation** concerns the **provision and use of services within the service delivery system and program established by a local project. How are services actually provided and utilized? What are the factors that affect utilization?**

The answer to these questions includes studying family members' goal attainment, service content and frequency of delivery, and features in the organization of each CCDP project.

MODEL OF FEASIBILITY

The feasibility model proposed here contains four general components that affect the development of a project's service organization (see Figure 1 on the next page). These components are (1) the community resources and support (e.g., service delivery systems), (2) characteristics of the grantee agency, (3) the project's resources (e.g., space, personnel), and (4) characteristics of the program's clients (e.g., family needs and structure). Each of these components is described in more detail below, highlighting some of the factors involved in program implementation. Aspects of these components not only affect the feasibility of the CCDP program, but also relate to each other in terms of local project requirements to meet service needs. Their interrelationships also will be examined.

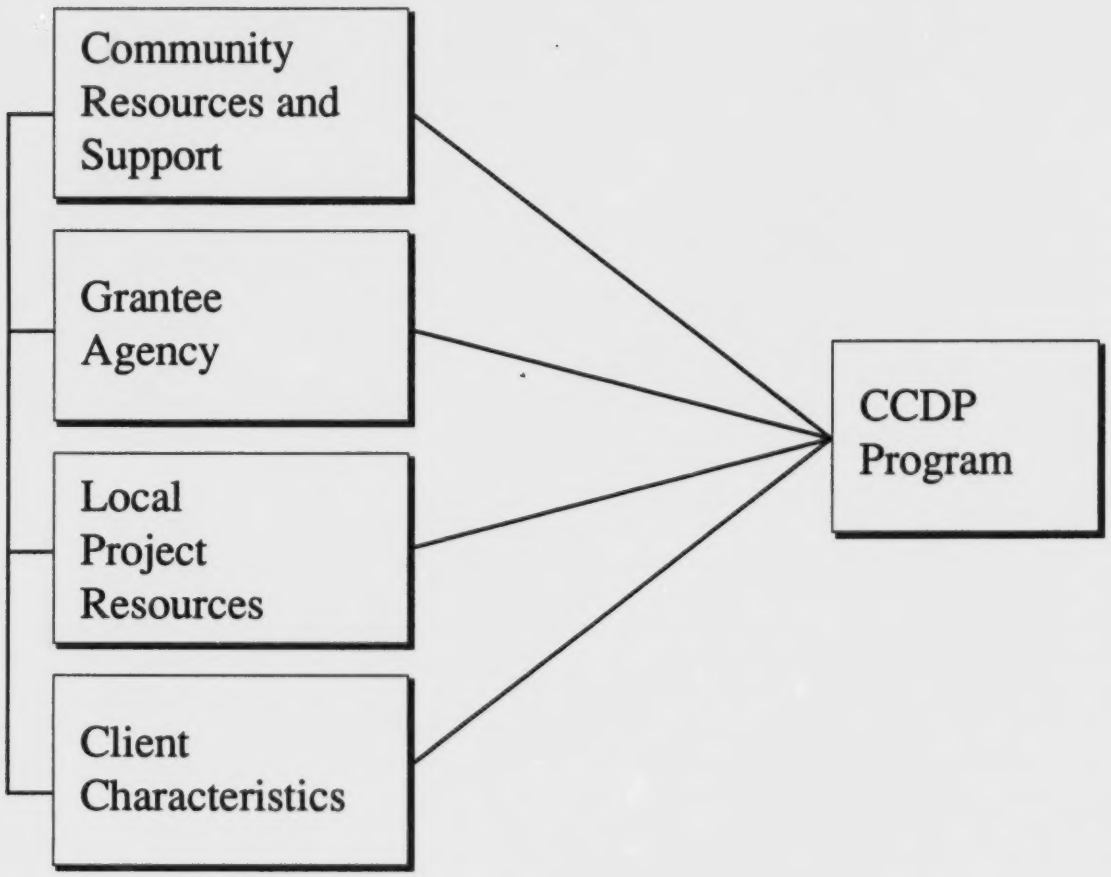
Community Resources and Support

A major feature of a coordinated service system for CCDP families is the development of cooperative arrangements and agreements between the CCDP project and other service agencies and the strength and duration of community agency support for CCDP. An aspect of feasibility then is the availability and quality of other services in the community and the response of public and other community agencies to the local CCDP project and to its mission. The history of interagency cooperation and service integration that existed in the community prior to CCDP implementation also likely influences program development. Finally, different attributes of rural and urban settings may influence feasibility.

Grantee Agency

The type of grantee agency may differentially influence project development. First, it can determine what services the CCDP project will provide itself, and which services are provided through referral and cooperative arrangements. For instance, coordinating health services for CCDP families may be less of an issue in program development for a grantee that is a major community health agency. The type of agency also may affect staff recruitment and development requirements. For instance, a family services agency with a history of previously providing community outreach and case management services may have fewer staff development requirements or problems in implementing a case management function. Finally, and likely an important factor in initial implementation, is the stature and leadership role of the grantee agency in the community. It is, for example, reasonable to expect that the establishment of coordinated services for CCDP families with other agencies would be facilitated for a grantee agency that already has a major leadership position in community services.

Figure 1
Model of Feasibility



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Local Project Resources

Local project resources include factors like the availability and adequacy of office space, qualified staff, staffing levels, funds, services, materials, and transportation as well as management organization and strengths. A project's ability to serve families effectively can be affected greatly by the administrative characteristics of both the project and its parent agency. For example, inadequate office space, too few staff to service families effectively, or even the lack of experience of an agency in administering a large, complex Federal grant directly relate to the feasibility of project implementation.

Client Characteristics

Client characteristics include demographic characteristics of CCDP families, the level and extent of needs, their cultural values, and their attitudes toward the program and the wider community service system. These characteristics are evident both across and among families. Families of varying structures or educational levels may exhibit varying levels of ability and/or willingness to participate in CCDP activities. Also, individual characteristics such as the desire for a better life or values supporting education and the work ethic can affect families' participation levels and ultimate program feasibility.

MODEL OF SERVICE UTILIZATION

The service utilization model proposed here contains three general components that affect service utilization: (1) the community setting, (2) family needs and goals, and (3) the CCDP program (see Figure 2). Each of these components is described in more detail below, highlighting likely factors affecting service utilization. This model addresses the second research question in the evaluation of implementation which concerns the provision and use of services within the service delivery system established by a local project. This part of the evaluation will examine the frequency and quality of services provided and used, the barriers to service use, the relationship of family needs and goals to service use, the degree of family goal attainment, and the effect on family participation of both the community setting and the attributes of the CCDP coordinated service system.

Community Setting

The community context has been noted as a factor in the feasibility of the CCDP program, in part, via the available resources to build a coordinated service system for CCDP families. Other community resources such as available housing, public transportation, and employment opportunities also may affect service utilization. The community context may affect utilization via the existence or nonexistence of social support and belief systems that encourage and facilitate utilization. For example, community values that support educational and discourage dependence on government support may affect families' use of and participation in the CCDP program. The community characteristics, such as its urban or rural nature, crime level, prevalence of drug use, and poverty level also may affect utilization.

Family Needs and Goals

A common goal of the CCDP program, as noted earlier, is that services are provided and utilized to address family needs and goals. This CCDP goal suggest two analytical issues: 1) the types and extent of family needs within and across CCDP programs and how they relate to actual service use; 2) the degree to which families attain their goals. We will examine the degree to which services are developed or available to meet family needs. This examination relates to the interaction between this component and the next one in the model, the CCDP program.

CCDP Program

The CCDP program operations encompass: the quality and availability of the services it provides, the delivery system used, the staff, the organizational structure, the facilities, the philosophical approach and curricula used, and the interrelationships with cooperating agencies. The question for service utilization is whether, or how, program operations facilitate service use by families. For example, we will examine whether differences across projects in the service delivery system relate to differences in service utilization. Also of interest are common attributes in the service systems across projects that facilitate or impede the use of services to address family needs and goal attainment.

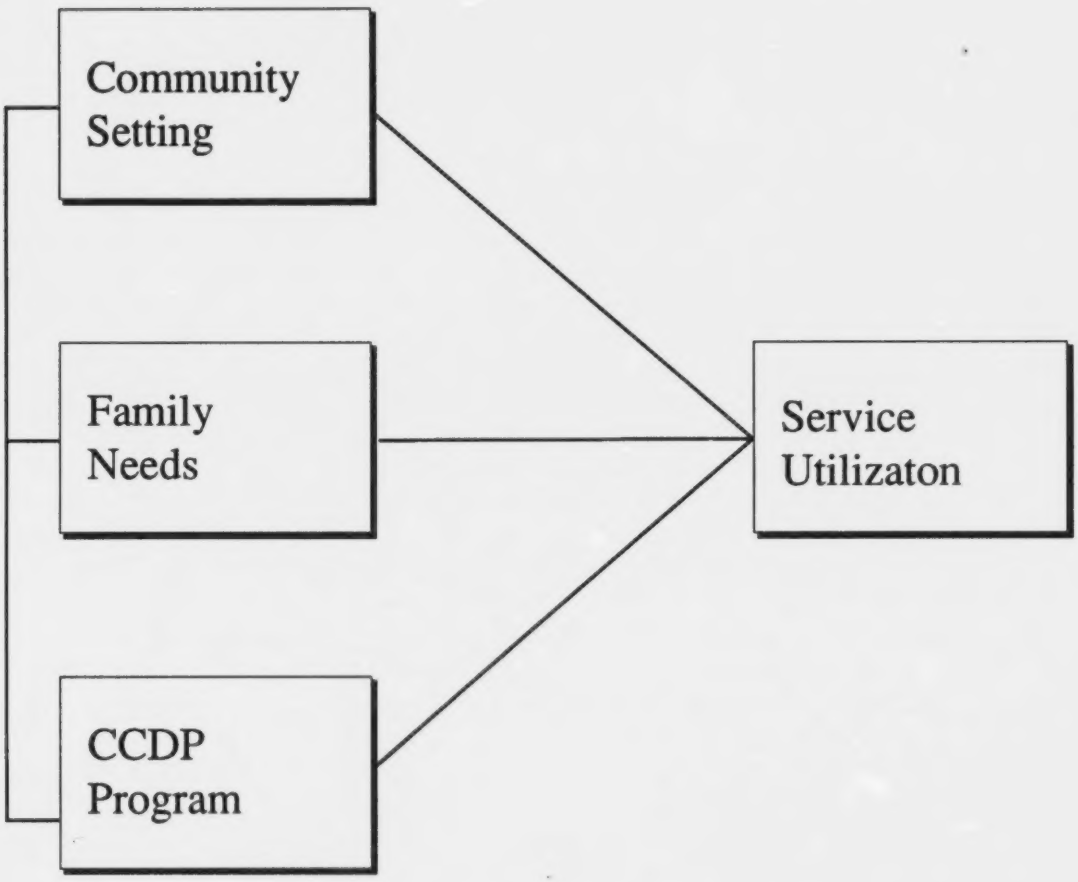
The study of service utilization will encompass both quantitative and qualitative analyses. In general terms, the quantitative analyses will indicate the statistical relationships among variables in the model of service utilization. The qualitative analyses will, in part, reveal processes in the development and provision of services that underlie some of the quantified relationships, for instance, processes like the influence of the community context on the implementation of case management practice at a local project. In addition to the examination of the factors within each component of the model, we will also examine interrelationships between them, as the interrelationship between family needs and goals and the CCDP program.

DATA SOURCES

There are five major sources of data for conducting the feasibility and process evaluation:

- project proposals;
- quarterly progress reports and other project documents;
- ethnographer reports;

Figure 2
Model of Service Utilization



- reports from site visits conducted by ACYF and CSR and subsequent action plans submitted by grantees; and

- the Management Information System (MIS) and time allocation studies.

Data Sources in Feasibility Analysis

Projects' proposals, progress reports and action plans provide information on the formal structure of the service network (e.g. interagency agreements and services provided by the CCDP project), and the progress and changes in program development and management (e.g. staff hiring, personnel functions, family recruitment). Ethnographers' reports provide more detailed data on the process involved in program implementation, providing descriptions and insights on how community resources and supports, grantee agency attributes, local project resources, and family characteristics facilitate or impede program implementation. In short, the ethnographer's report provides data on the dynamics and natural history of a local project's implementation and ongoing operation. Site visits provide data on the status of program development in terms of the design and intent of the CCDP national demonstration program. The MIS provides more quantitative data on families, and service descriptions relevant to feasibility questions.

Data for the cost analysis will come from the MIS and time allocation studies. The MIS will contain the unit costs for services provided through some interagency contracts and agreements. Time allocation studies will determine the CCDP staff costs for different service areas. The cost analysis will identify variations in costs associated with different project arrangements for coordinating and providing services.

Data Sources for Analysis of Service Utilization

Quantitative Data

Quantitative measures of the community setting will primarily come from social indicator databases such as that from the 1990 Census. The plan is to use the MIS for the quantitative analyses of family needs and goals, CCDP program characteristics, and service utilization. Some of the MIS data are:

- *Family Needs*. The two major forms in the MIS for family characteristics and needs are the Family Profile form and the Family Assessment forms. Family and individual family member goals, as well as the effort and progress in goal attainment, are recorded on the Family Assessment form. The services planned to address family goals are recorded on the Family Service Plan form. In addition, the Developmental Screenings and Assessment Form provides the results of those tests on children in the families. In total, these data sources in the MIS will allow analyses of the relationship between needs, goals, stated plans and progress on goals.

- *CCDP Program.* The MIS' Service Location Profile describes the service programs and locations in each project. This description includes data on the services provided and staff. Other forms contain data describing child and adult educational programs and activities. MIS data on a project's staff enables measurement of such organizational/case management features as staff qualifications, staff turnover, and staff caseloads.

  From these data, the attributes of the service delivery system of local projects can be discerned. For instance, in some analyses, projects can be categorized by a service organizational dimension (e.g. degree centralized vs. decentralized service network and/or types of case management organization) and analysis of variation in service use by families across the categories of sites could be conducted.

- *Service Utilization.* The MIS includes data on utilization across the array of services provided, such as frequency of home visits, day care use, adult education attendance, and health service utilization. In addition, the tenure of a family in the program is to be captured by the MIS. Tabulations of services received can be made as well as analyses of the relationships between services received and family goals.

Qualitative Data

There are two main sources of qualitative data for addressing issues regarding the provision of services: reports from site visits conducted by ACYF and CSR personnel, and the reports from the project ethnographers. The site visits conducted by ACYF and CSR personnel provide some measures of the content and quality of services which might relate to service use and degree of family goal attainment. Ethnographers' reports not only provide more detailed data on the process of program implementation, but also on the operations of the program and delivery of services (see Appendix I, page A-19). The focus of case study reports from ethnographers will change over the course of time from analyses that reveal start-up developments and descriptions of the organization for core services, to analyses that depict how the community setting, family needs and service organization are manifested in the process of service delivery. Data will also include descriptions of staff perspectives, the issues and work involved in the case management of CCDP families, and characteristics of family participation. In short, the case study material will provide data for describing and understanding the processes and context of service utilization.

The general purpose of the feasibility and process evaluation is to provide information that will be useful for policy on future program enactment and design. The assessment of feasibility and program operation can assist in making judgments about initial program success. But the overall evaluation will also provide more understanding of the processes occurring within and across sites to identify any modifications in program design that might lead to further benefits if implemented on a broader scale.

This report partly addresses the question of feasibility, providing a preliminary assessment of program startup issues experienced by projects and describing program design and operation during the first 18 months. More indepth analysis of components in the models outlined above will be in future reports.

METHODOLOGY FOR THE REPORT

The findings in the following sections provide quantitative and qualitative data from the MIS and the ethnographer reports, proposals, quarterly progress reports, and site visit case studies. Findings are presented to respond (to the extent possible) to the management analysis questions described earlier primarily for the 22 projects in operation in the first year. (In a few cases data were available for 23[4] or 24 projects and are so reported.) Site visit data are from the first 12 site visits conducted.

Because the MIS was not implemented at the time the analyses for this report were begun, only recruitment data are available from it. Data sources for each section of the findings are presented below.

Description of sites	Proposals, quarterly reports
Characteristics of enrolled families	MIS
Program startup and implementation	Ethnographer reports, quarterly reports, site visit reports, interagency agreements
Service delivery characteristics	Ethnographer reports, quarterly reports, site visit reports, and proposals
Attrition	Data compiled by projects from recruitment records
Summary of site visit findings	Site visit reports and correspondence (12 sites)

For this report, likely factors under each of these components were initially outlined and data sources from each site reviewed to abstract data relevant to each outlined factor. This data abstraction in some cases simply involved coding whether or not a factor was mentioned in some fashion as either a positive or problematic attribute of the project's start-up (for example, whether or not obtaining office space or hiring staff was an issue). In essence, this part of the data abstraction was largely a codification of either the perceptions and impressions of site staff or the observations of the site ethnographer. For other factors,

[4] One project has not been included because complete attrition data on all families recruited were not available. The twenty-fourth project had not recruited families at the time of this analysis.

such as degree of staff turnover or number and types of interagency agreements, the frequency or number of occurrences at a site were extracted from the reports.

In addition to the categorical and numerical coding of data, the site ethnographers' reports on sites' development were reviewed for qualitative analysis that might reveal or suggest *how* different startup issues (both positive and problematic) were manifested in the process of sites' development. The ethnographers' quotes cited in the text were selected for their relevance in illustrating a finding identified by a number of projects.

For the attrition data analyses, one project is not included because complete data on all families recruited were not available. The twenty-fourth project had not recruited families at the time of this analysis.

CHAPTER 3: CCDP PROGRAM CHARACTERISTICS

This chapter is divided into six sections as follows.

- Description of sites;
- Characteristics of enrolled families;
- Program startup and implementation;
- Service delivery characteristics;
- Attrition; and
- Summary of site visit findings.

DESCRIPTION OF SITES

Consistent with the legislation's intent to examine CCDP feasibility and effectiveness across a wide variety of environments, the projects are varied in terms of the number of families they serve, the type of umbrella agency administering the program, and their location and setting. These characteristics are summarized in Table 2 on the following pages. The legislation and the Federal Register announcement established some parameters within which the projects designed their programs. Other aspects were unique to the individual project.

Number of Families To Be Served

The Federal Register announcement required that urban projects serve at least 120 families and rural projects serve at least 45 but preferably 60 families. According to the population density they serve, the following six projects are categorized as rural:

- Brattleboro, Vermont;
- Nashville, Tennessee;
- Glenwood City, Wisconsin;
- Fort Totten, North Dakota;
- Logan, Utah; and
- Marshalltown, Iowa.

Some of these grantees (e.g., Nashville) are located in cities but serve only rural, outlying communities. Marshalltown, Iowa, serves 98 families and Fort Totten, North Dakota, serves 45 families.

All urban sites serve 120 families except Albuquerque, New Mexico, which serves 180, and Washington, D.C., which serves 160.

Grantee Agency

The kinds of agencies that received CCDP grants are varied. The umbrella agencies that have administrative/fiscal responsibility for the grants include six community/family services centers, six colleges/universities (including two university hospitals), four community action agencies, three health centers/clinics, two child development/day care organizations, one school district, one foundation, and one city administration. In addition, six sites also are Head Start grantees: Denver, Colorado; Washington, D.C.; Miami, Florida; Lexington, Kentucky; Nashville, Tennessee; and Fort Worth, Texas.

Geographic Location

CCDP projects are located in each of the ten DHHS regions in the United States: Two of the projects are in Region I; one is in Region II; three projects are in Region III; three projects are in Region IV; two are in Region V; five projects are in Region VI; two projects are located in Region VII; three are in Region VIII; another two are in Region IX; and one project is in Region X. The geographic diversity of project sites contributes to wide variation in the cultural and ethnic composition of CCDP families, which is described later in the section on family characteristics.

Staffing Pattern

Grantees have a variety of staffing configurations, but they share some common elements (see Figure 3 on the following page). All projects have case managers or home visitors. These positions have varied names, e.g., family advocates, family consultants. All CCDP projects have a project director, executive director (of the grantee agency), and a data manager. More than 60 percent of the projects have an early childhood education coordinator or director, and more than 60 percent have a case management coordinator or supervisor. Almost 60 percent have a staff member who coordinates adult training and education. About one-third of the projects have a health coordinator. More than 40 percent of the projects operate their own child care centers and have teachers and teacher aides on staff.

Projects differ with regard to the titles they use for the positions mentioned above. In addition, all projects except for one have staff members who carry a caseload of families; these staff members provide case management and often early childhood services to families. Some projects use a team approach in which staff members with varied expertise serve a group of families. These approaches are described in detail in the section on case management.

To provide an illustrative example of a staffing pattern, Figure 4 displays a chart of the organizational structure at a typical site.

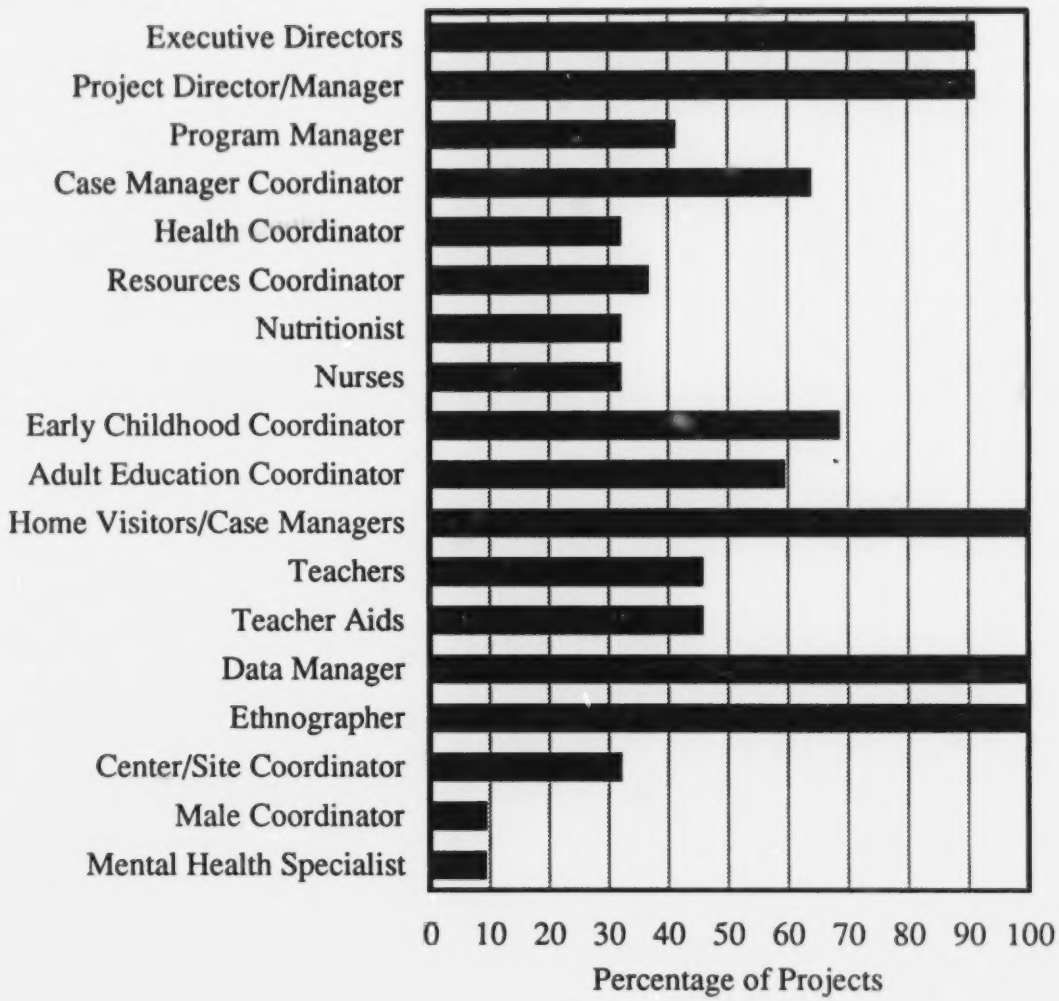
Table 2
Description of Programs

Name of Project	No. of Program Families	Location	Grantee Agency	Setting	
				Rural	Urban
REGION I					
Project AFRIC	120	Roxbury, MA	Community Health Center		X
Windham County Family Support	60	Brattleboro, VT	School District	X	
REGION II					
Project CHANCE	120	Brooklyn, NY	Family Services Agency		X
REGION III					
Parent-Child Resource Center	160	Washington, DC	Day Care		X
Family Start	120	Baltimore, MD	Family Services Agency		X
Family Foundations	120	Pittsburgh, PA	University		X
REGION IV					
Toddlers, Infants, Preschoolers, and Parents (T.I.P.P.)	120	Miami, FL	Community Action Agency		X
Operation Family	120	Lexington, KY	Community Action Agency		X
Tennessee CAREs	60	Nashville, TN	University	X	
REGION V					
Project Focus	120	Grand Rapids, MI	Family Services Agency		X
West CAP Full Circle Project	60	Glenwood City, WI	Community Action Agency	X	

Table 2
Description of Programs (continued)

Name of Project	No. of Program Families	Location	Grantee Agency	Setting	
				Rural	Urban
REGION VI					
Project Family	120	Little Rock, AR	University Hospital		X
Families in Partnership	180	Albuquerque, NM	City Administration		X
Primero Los Niños	120	Las Cruces, NM	Health Agency		X
AVANCE	120	San Antonio, TX	Family Services Agency		X
ShareCare	120	Fort Worth, TX	Day Care Association		X
REGION VII					
Mid-Iowa Community Action	98	Marshalltown, IA	Community Action Agency	X	
Project EAGLE	120	Kansas City, KS	University Hospital		X
REGION VIII					
Family Futures	120	Denver, CO	Foundation		X
Little Hoop CCDP	45	Fort Totten, ND	Community College	X	
Community-Family Partnership	60	Logan, UT	University	X	
REGION IX					
Conocimiento	120	Phoenix, AZ	Family Services Agency		X
ENRICH	120	Venice, CA	Health Clinic		X
REGION X					
Families First	120	Auburn, WA	Family Services Agency		X

Figure 3
Staff Positions



N=24 Projects

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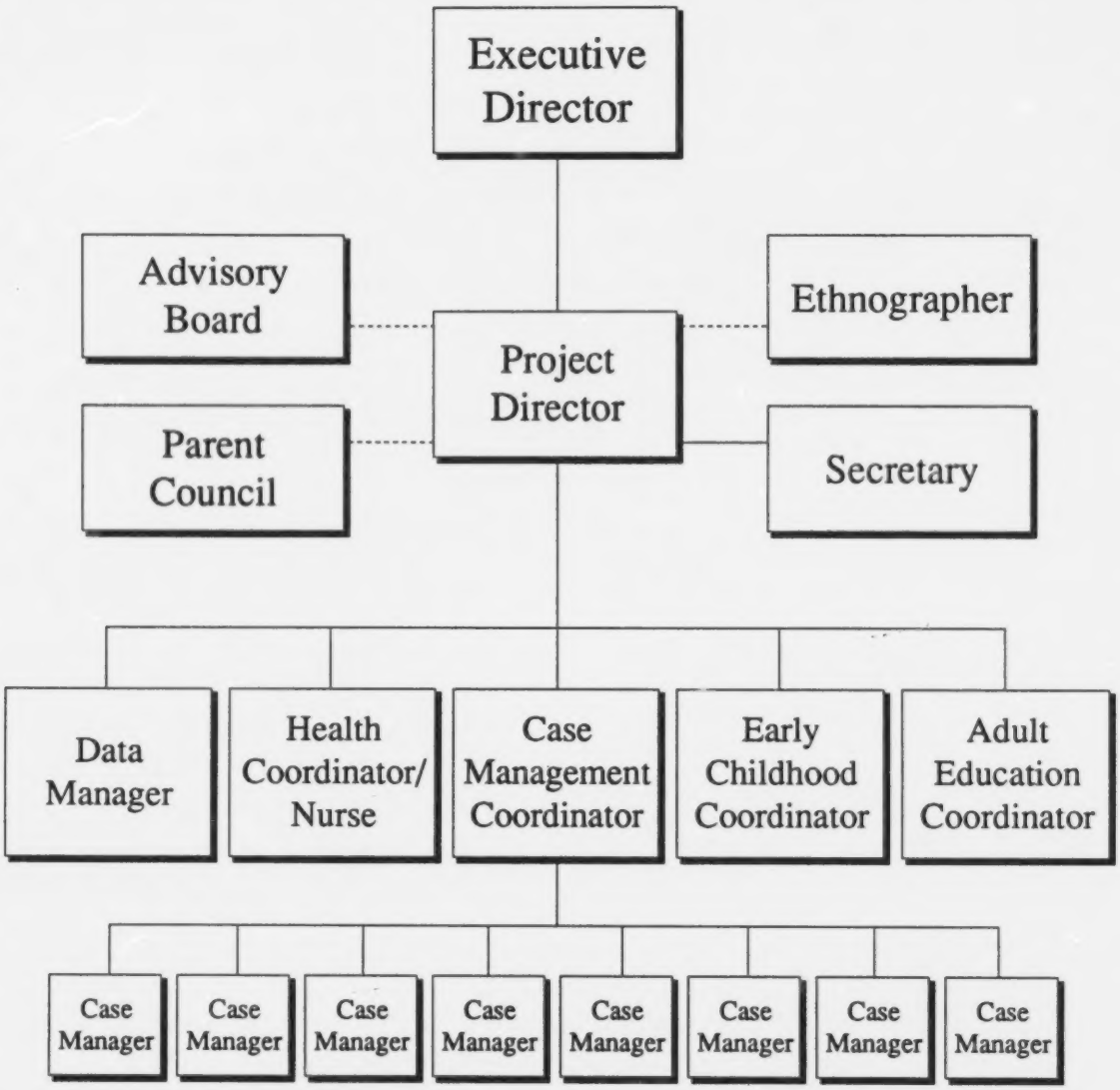
Figure 4
Sample Organizational Chart for a CCDP Project



CHARACTERISTICS OF ENROLLED FAMILIES

Recruitment Eligibility

In order to test program effectiveness most accurately, CCDP was established as a demonstration program incorporating an experimental design. Eligible families in each community were recruited and then assigned randomly to program (treatment), comparison (control), and replacement groups.

There were three eligibility criteria for all families recruited for CCDP. First, families had to have had an annual income that was below the 1989 Federal poverty guidelines (income for a family of four could not exceed $12,000). The income of all family members was entered into the calculation for determining a family's eligibility for the program (ACYF Information Memorandum ACYF-IM 89-13 includes 1989 income guidelines and eligible sources of income).

The second eligibility criterion was that the family must have had an unborn child or a child under one year of age, designated as the "focus" child for eligibility purposes.

The third criterion was that, at the time they were recruited, all families must have agreed to participate in CCDP activities for 5 years.

Characteristics of families, such as income, are expected to change over time as families move toward self-sufficiency. The decision was made by ACYF that if a family is participating in CCDP and the family's income rises above the poverty line at any time over the 5 project years, the family may remain in the project.

In addition, projects had to select families such that projects would be representative of the demographic composition of their communities with respect to race/ethnicity and percentage of teenaged parents.

Twenty-three projects had recruited 6,593 families by the end of calendar year 1990.[5] These were to be randomly assigned to program (treatment), comparison (control), and replacement groups. Eleven projects selected three times the number of the desired program group and randomly assigned families to the three groups. Eleven projects had difficulty recruiting a pool triple the size of their program group and were given permission to reassign their replacement families randomly to fill the program/comparison groups. They then continued recruiting replacement families to create as large a pool of replacements as needed.

[5] Projects contacted more families than those for which data are available. For instance, some families contacted who later were lost, refused further participation, or were determined to be ineligible are not included in the pool reported here.

Of the families initially recruited, 2,549 are program, 2,410 are comparison, and 1,634 are replacement. The data presented below are for program families only; data on comparison families are virtually identical.

Family Composition

MIS data are not yet available to provide a breakdown of family composition by each of the projects. However, numerous family composites were evident through reports by projects during the recruitment process. Some examples of family compositions which are characteristic of CCDP families are: a married couple in which the mother is pregnant and/or has a child under 1 year and other children; a single pregnant woman; a single parent and her/his child under 1 year and other children; a teenaged parent residing in the same household as her parents in which the grandparents provide major nurturance to the focus child; a single pregnant woman or single parent with child under 1 year, residing with an unmarried partner in the same household; and a single parent and focus child *and* the nonresident parent of the focus child (absent father).

Ethnicity

Recruited families are proportionately representative of the poverty population of the grantee's recruitment area in terms of ethnicity. Grantees submitted community data with recruitment area population characteristics based on sources such as a community needs assessment, U.S. Census data, State or county surveys, or other appropriate sources.

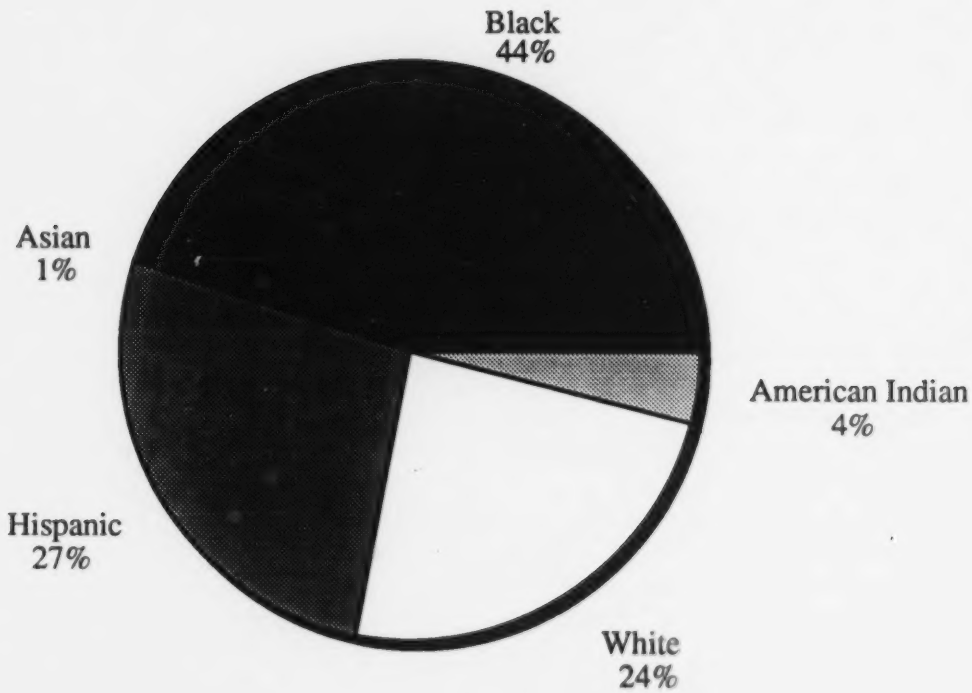
During the recruitment phase and based on grantee recommendations, the ethnicity of families was classified according to the following categories: African American; American Indian; Asian; Latino; white; other. These categories were modified in December, 1990, to be congruent with the ethnicity categories adopted by the 1988 U.S. Census and approved by OMB. The new ethnicity labels, which are being utilized by all projects, are the following:

- American Indian or Alaska Native;
- Asian or Pacific Islander;
- Black, not of Hispanic origin;
- Hispanic; and
- White, not of Hispanic origin.

The following data include information about family ethnicity at 23 projects through the use of the OMB-approved ethnic categories.

Of 2,549 program families recruited, the largest group is black, non-Hispanic (44 percent), followed by Hispanic (27 percent), white, non-Hispanic (24 percent), American Indian or Alaska Native (4 percent), and Asian or Pacific Islander (1 percent) (see Figure 5 following this page). These percentages vary across projects. Sixteen projects have a much higher percentage of one ethnic group than the other groups.

Figure 5
Ethnic Representation of All Program Families Recruited



N=2,549 Program Families From 23 Projects

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Figure 6 displays the percentages of ethnic categories for sites in which most families are Hispanic. Five projects have a predominantly Hispanic population. A site is categorized as having a predominant ethnicity, such as Hispanic, if 60 percent or more of the families at the site represent one ethnic category. Of the recruitment information obtained from 683 program families at these five projects, 74 percent of the families are Hispanic; 11 percent are white, non-Hispanic; 11 percent are black, non-Hispanic; 3 percent are American Indian or Alaska Native; and 1 percent are Asian or Pacific Islander.

The ethnic breakdown for predominantly black, non-Hispanic projects is presented in Figure 7 following this page. At these sites, based on recruitment information from 10 projects, black families comprise 74 percent of the participant families; Hispanics, 11 percent; whites, 12 percent; and American Indian, Alaska Native, Asian, or Pacific Islander, 2 percent.

Figure 8 displays percentages of ethnicity for five projects that have a predominantly white, non-Hispanic population. For the 380 families included in these projects, 83 percent are white, 6 percent are American Indian or Alaska Native, 5 percent are black, 3 percent are Hispanic, and 3 percent are Asian or Pacific Islander.

Figure 9 displays the ethnicity categories for two projects that are considered not to have a predominance of one ethnic group over the others. Based on recruitment information for 258 families at these sites, 53 percent of the families are black, non-Hispanic, 31 percent are white, non-Hispanic, 16 percent are Hispanic, and less than 1 percent are in the other categories. One remaining site had 98 percent American Indian families and 2 percent white families.

Age of Parent or Primary Caregiver

The age of the parent or primary caregiver of the focus child, specifically whether the caregiver is a teenager or not, is another stratum for which program families are proportionately representative of the poverty population in projects' recruitment areas. Figure 10 presents the proportion of primary caregivers who are adolescents, based on recruitment information obtained from 23 projects. Adolescent caregivers are defined as being 19 years of age or younger. Of 2,549 program families, 28 percent have an adolescent who is the primary caregiver for the children.

The primary caregiver was between 20 and 25 years of age in 40 percent of the families at time of recruitment.

Size of Household

The number of persons in family households is available for 2,549 program families, based on recruitment information obtained from 23 projects. The data indicate that these programs serve a total of 9,413 members and that the average household size is 3.7 members (standard deviation=1.71).

Household Income

Among 2,549 families recruited during 1990 for the program, the average annual household income at the time of recruitment was $5,707 (standard deviation=$3,695). The majority of the households, 62 percent, had an annual income of $6,000 or less, while 20 percent had an income between $6,001 to $9,000, and 12 percent had an income between $9,001 and $12,000. Only 6 percent of the households had an annual income above $12,000 (see Figure 11 following this page).

Fathers in Households

Information on fathers living with families is available for 23 projects. These data come from preliminary family profile data obtained at program enrollment after recruitment, prior to formal implementation of the MIS and were not available for all families. Figure 12 shows aggregate data for the 2,376 CCDP program families enrolled in 1990 for which information was available; 872 families, or 37 percent, had a father living in the household. Specific projects vary on the percentage of fathers in family households. Two projects had 10 percent of the families with a father present, eight projects had between 10 and 29 percent, six projects had between 30 and 49 percent, four projects had 50 to 69 percent and three projects had 70 percent or more families with a father present.

Child Ages at Enrollment

Figure 13 on the following page displays the number of children under the age of 5 at the time of enrollment into the program. Among 2,376 families enrolled in the program in 1990 across 23 projects, there were 4,158 children under age 5. The majority of the children were under the age of 1 at the time of their family's enrollment—2,455 children, or 59 percent. (All families had at least one child under age 1 or unborn at recruitment.) There were 560 children 1 year old at enrollment in 1990 (14 percent), 457 were 2 years old (11 percent), 378 were aged 3 (9 percent), and 308 were 4 years of age (7 percent). The average age at enrollment of the children *under the age of 5* was 1.3 years (standard deviation=1.43).

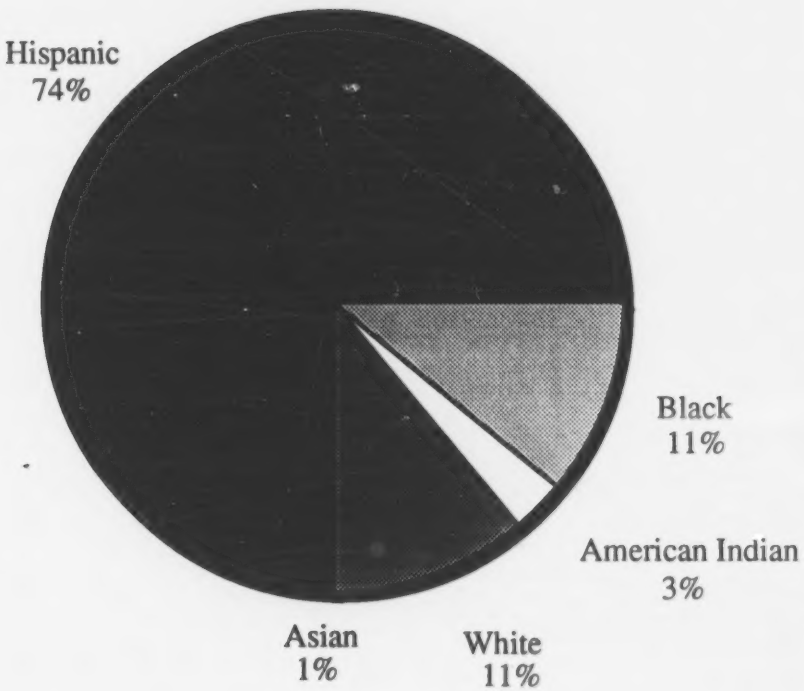
In conclusion, CCDP families are most likely to be headed by very poor, single mothers, the majority of whom are minorities. These mothers are young (most under 25 years of age) and had a child under 1 year old at recruitment plus at least one other preschool- aged child.

The following section describes the startup and development of the CCDP programs designed to serve these families.

PROGRAM STARTUP AND IMPLEMENTATION

CCDP is the actualization of two major programmatic movements in human services delivery and child development that have emerged over the last twenty years. The first major

Figure 6
Ethnic Representation for Projects With a Predominance of Hispanic Families



N=683 Program Families From 5 Projects

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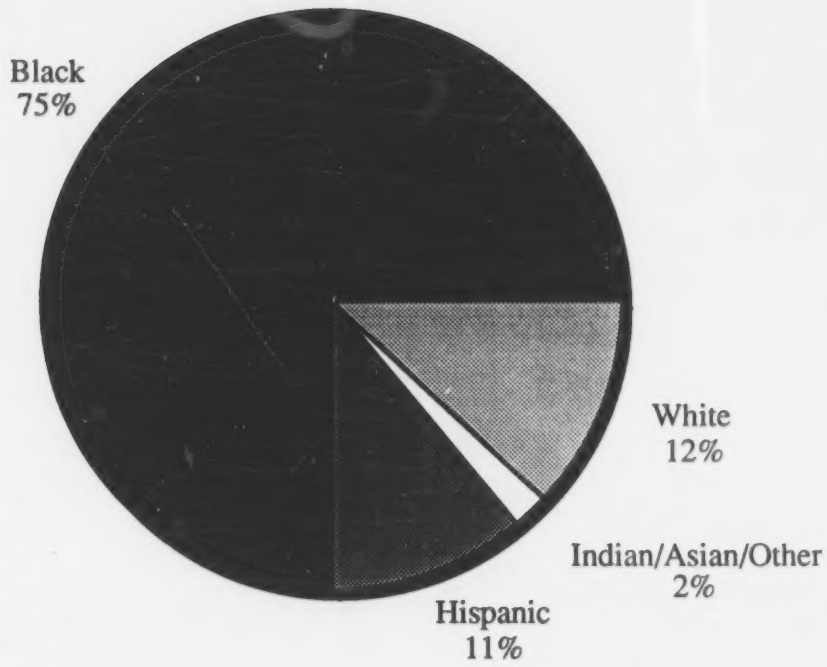
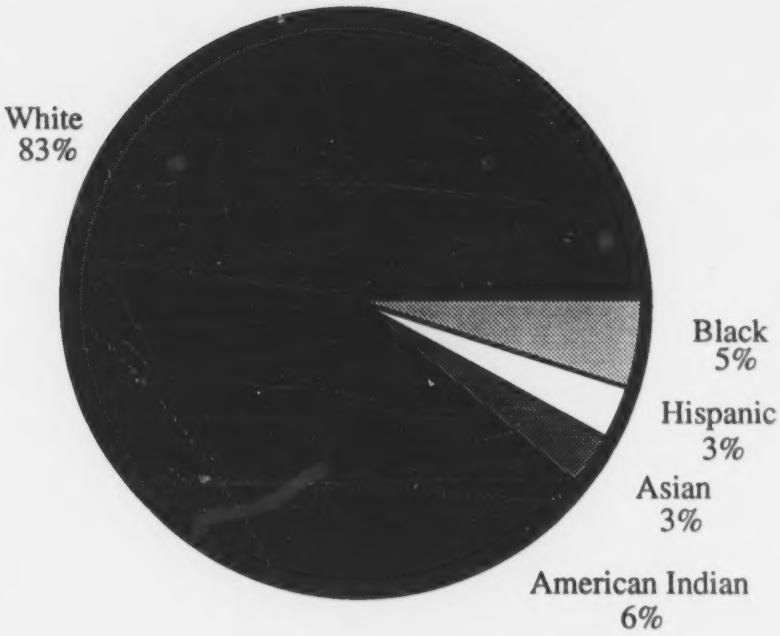
Figure 7
Ethnic Representation for Projects With a Predominance of Black Families



N=1,186 Program Families From 10 Projects

#09191

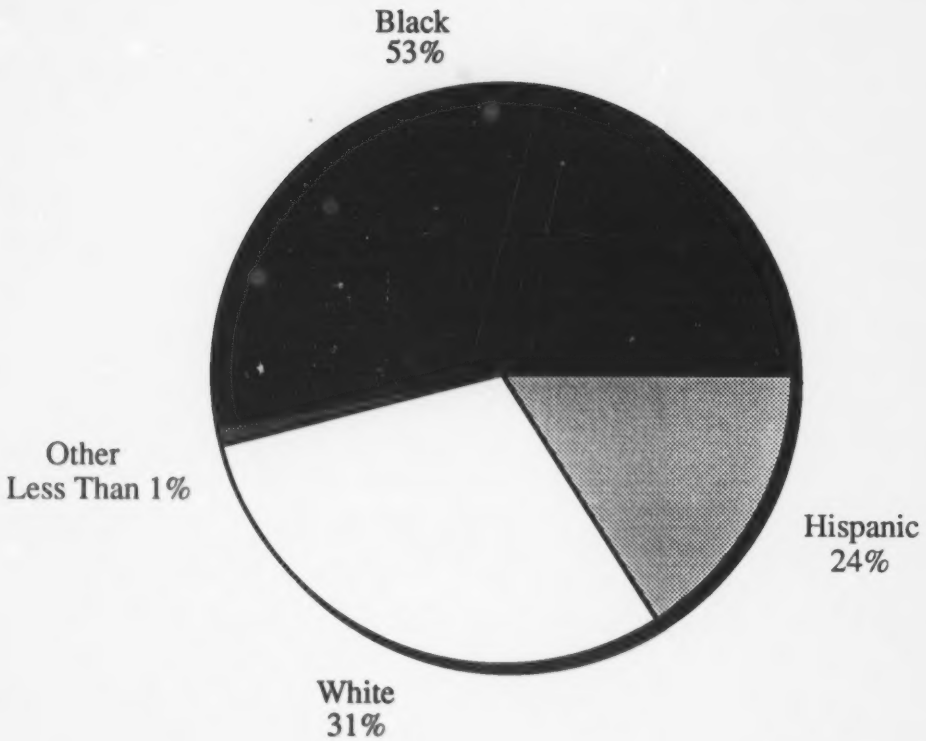
Figure 8
Ethnic Representation for Projects With a Predominance of White Families



N=380 Program Families From 5 Projects

#09191

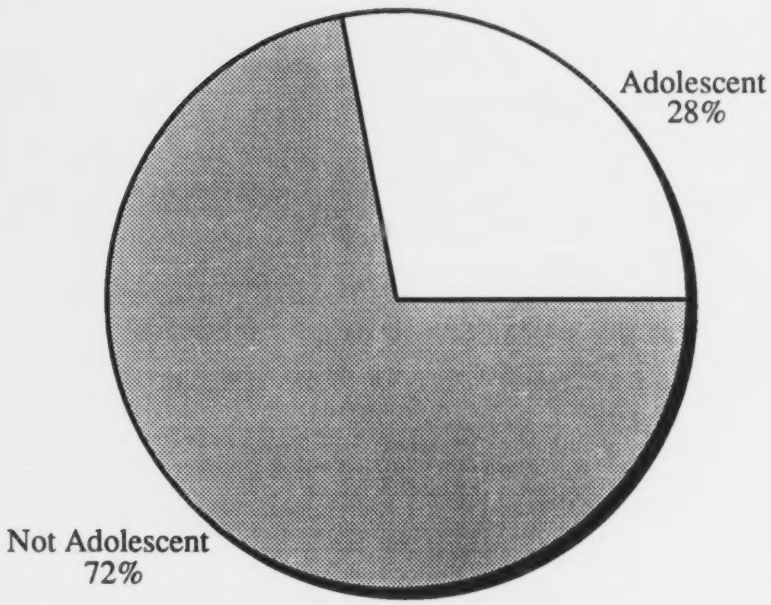
Figure 9
Ethnic Representation for Projects With Varied Ethnicity Among Families



N=285 Program Families From 2 Projects

#09191

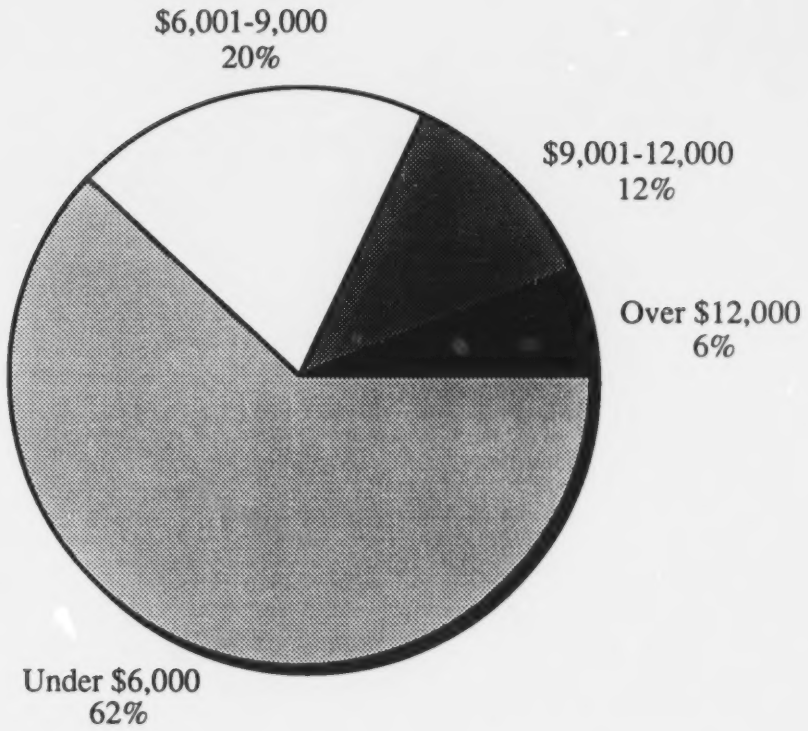
Figure 10
Percentage of Families With Adolescent Primary Caregivers



N=2,549 Program Families From 23 Projects

#09191

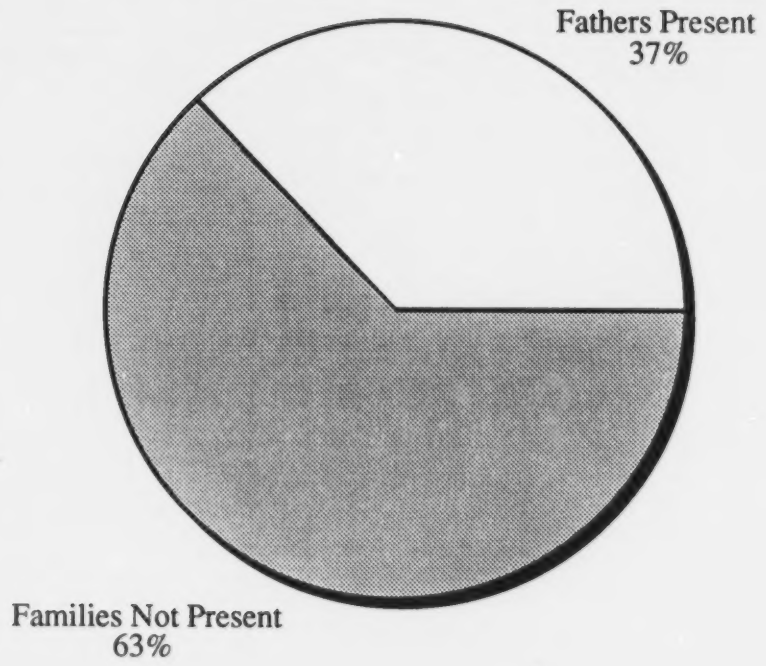
Figure 11
Annual Family Income at Enrollment



Mean Family Income = $ 5,707
N=2,549 Program Families From 23 Projects

#09191

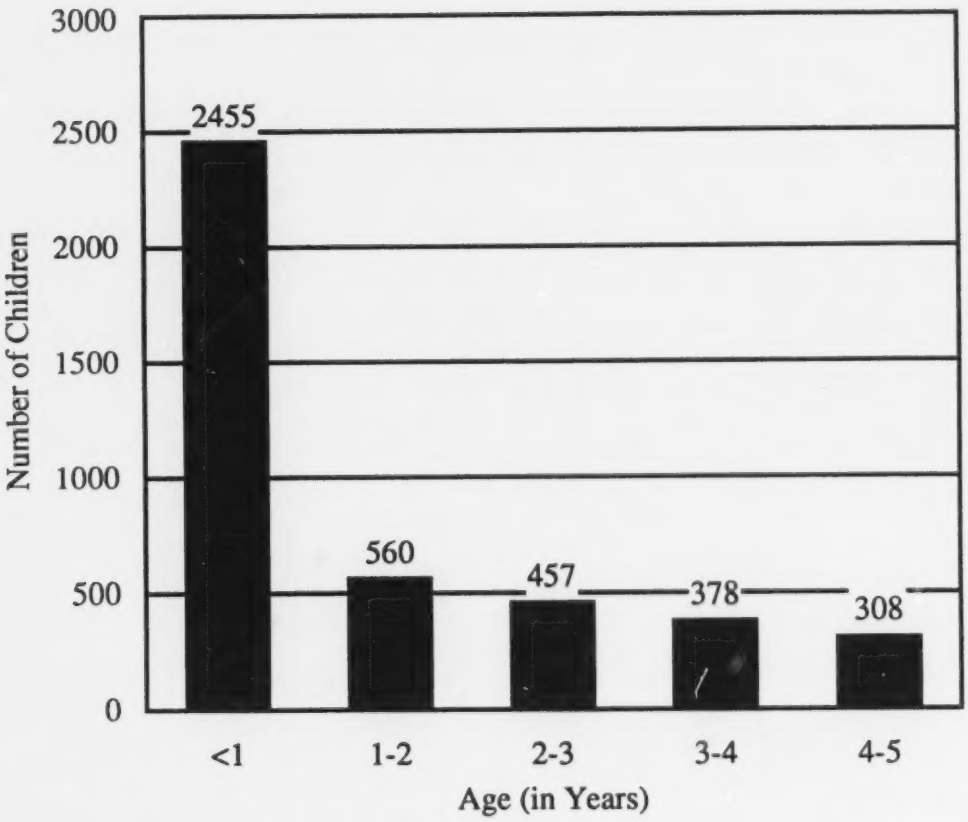
Figure 12
Percentage of Program Families With Fathers Living in Household



N=2,379 Program Families From 23 Projects

#09191

Figure 13
Number of Children Under Age 5 in Program Families



N=4,158 Children Under Age 5 From
2,376 Program Families From 23 Projects

#09191

emphasis is the development of a comprehensive program to intervene in the lives of low-income families much earlier than had been done before. Rather than waiting until children are three or four, CCDP projects intervene in the first year of life or prenatally to promote optimal child health and development, skilled parenting, and family self-sufficiency. The focus is on the entire family, not just the child, and CCDP emphasizes the crucial role of parents in child development.

The second thrust is the integration of these comprehensive family programs with other human services to increase the program's effectiveness, utilization, and efficiency in serving this low-income population. This integration of services is a comprehensive effort to address all service needs together rather than in discontinuous parts where the lack of a critical service may render other services ineffectual.

Services integration has been attempted since the early 1970's in varying contexts and with varying degrees of success. In services to children, the Appalachian Regional Commission's (ARC's) State and local child development councils formed around the incentive of ARC program funds. The Comprehensive, Coordinated Child Care (4-C) program of the OCD promoted voluntary coordination of services, but the lack of funding limited its success. The Office of Maternal and Child Health's coordinated, case-managed, family-centered demonstration grants in the late 1980's tested the approach for children with special health care needs. DHHS also has promoted human services integration in selected States through its Services Integration Pilot Projects (SIPP) program.

CCDP projects were charged with implementing services integration for families by building external networks with community agencies for services to support and complement the direct child and family services provided by the project itself. To implement this integrated network, CCDPs had to network within the community and develop both formal and informal relationships that would provide breadth to the services that they planned to provide.

During the grant writing stage of each project, these relationships generally were restricted to the solicitation from community agencies (e.g., health departments, departments of social services, day care providers, county extension agents, mental health agencies, Job Training Partnership Act [JTPA] grantees) for an acknowledgment of the goals of the emerging program and assurances of continued support. Following the award of grants, however, the same agencies that provided verbal support were reapproached, and formal negotiations commenced to provide a framework for the level of support that would actually be provided and for the identification of specific services that might be forthcoming.

The types of support that were elicited helped to expand and solidify the internal and external relationships that had been developed by the CCDP grantee. In some cases, community providers actually "came onsite" to provide, for example, medical support through the operation of an onsite clinic. In others, agencies agreed to relocate staff members on a part-time basis to provide onsite assessments and counseling services to CCDP families. Many agencies agreed to provide external support through the development of preferential

service arrangements for CCDP families that were referred to them. Child care arrangements, for example, were developed with local providers to ensure the availability of child care slots for parents who would eventually spend longer and longer periods out of the home as they attended classes and support group functions and secured employment.

Advisory Boards

Additional support was elicited through the formation of an advisory panel of key community leaders who would be representative of the community and could share their expertise in the development of CCDP activities. Although the specific role of the advisory panel was largely left up to the grantee and its panel members, ACYF provided guidance on the composition of the panel in the Federal Register announcement by requiring that the panel include: CCDP families, business representatives, and community service providers. In all sites, advisory board members include representatives of the key agencies providing services to the CCDP project.

Strategies to develop community support and interagency relationships included the use of the advisory boards, staff meetings, and individual staff member work. One project director indicated that the correct combination of both the advisory board and individual staff member work was crucial to development of community and agency support for a project. As this project director stated it:

> The Advisory Board is, typically, involved in a different way with planning. Typically, we will present the Advisory Board either with an issue or with an issue and several possible solutions and get their input on what they would advise us to do. Of course, their input is not binding. So far we've been able to utilize their advice very effectively because we've got a good Advisory Board who have good ideas and who have been able to suggest alternatives in some cases that we had not thought about....That's probably only one half of what we do [the Advisory Board] in terms of building community support. Community support is so critical to this particular project that we have spent a lot of time figuring out how to generate and maintain it. Clearly, a starting point was to get an advisory board representing primary agencies and get them involved with us even before the project was funded....(B)ut the real gist, if you will, for good community support has come from individual contacts with key agency personnel. We sat down and decided among the administrative staff who would be the liaison with each community agency. We knew that if we didn't coordinate things with an agency through one person, we would often have people working at odds within our own group with the same agency....So, we basically divided up the local and state agencies based on which of us already had ongoing contacts in places...If we had an agency we had not worked with...we assigned...someone....So, when you start looking at interaction with other agencies, there's a lot more going on than the Advisory Board and there's still a lot more that could be done. (Ethnographer Report, Site A,[6] October 1990).

[6] Each project is referenced using a different letter. The ethnographer quotes were selected for their relevance in illustrating a finding identified by a number of projects.

As with most program activities, the role and involvement of the advisory boards evolved and solidified over the year so that the boards became an increasingly valuable resource to the grantees.

Interagency Agreements

CCDP projects differ from one another regarding which services are provided to families directly by the project and which services are provided by other community agencies. The nature of the grantee agency and the types of services available generally determine which services the projects are able to deliver directly and with which agencies projects need to enter into contractual or brokering/referral arrangements in order for families to receive all CCDP core services. For example, projects whose umbrella agencies are health centers, clinics, or hospitals usually are strong with regard to providing health care to families and would be less apt to enter into agreements with other agencies for delivery of health services.

Formal relationships with other agencies facilitate the coordination of services and help to avoid duplication and gaps in services. Projects have developed written interagency contracts or agreements that delineate roles and responsibilities, activities, and timeframes for each agency. These agreements are intended to clarify expectations up front but allow for change over time as roles evolve. The agreements aid in establishing common definitions, including the definition of the population to be served, and lead to a better understanding of what agencies can expect from each other. Agreements serve as a means to inform staff members about available services and how to access them. Effective interagency agreements greatly facilitate the linkage of families with service providers:

> There is a fairly well-developed service network in place and functioning for the families in the [CCDP] project. What remains to be accomplished is the establishment of formal linkages—both inter-agency agreements with collaborating agencies and updated subcontracts with contracting agencies. Part of the delay in formalizing such links is the complexity entailed in translating working relationships into written agreements in a way that meets [project] needs and protects both [project] and the cooperating agencies from undesirable commitments and risks (Ethnographer Report, Site N, February 1991).

The inherent notion underlying the practice of establishing such agreements is that as projects are able to involve agencies with CCDP through written agreements, the nature of the involvement will become more committed and invested. Through cooperative agreements, projects can facilitate the delivery of services to families through sharing resources and can reduce "turf"-related issues that may be present. This is evident through one ethnographer's description of the environment in which her CCDP project started:

> Training centers and employers do not work together in most cases. A method which may prove useful for encouraging this partnership is creation of a task force that includes representatives from both training organizations and the business community. One training center in the area has tried this, but it has not been tried with a conglomeration of agencies. A major problem is the competition of agencies, educational institutions as well as nonprofit agencies. This competition is primarily over money, jobs, and people (Ethnographer Report, Site D, October 1990).

In another project, the interagency cooperation was more successful, as illustrated by the following:

> Although it is difficult to assess the amount of coordination among other community agencies, the level with [project] is remarkable. Community agencies are involved in all aspects of the program and some agencies that are interacting are ones that have not traditionally been called on to be active partners in a case management process. For example, the Health Manager has arranged for Immunization Outreach Clinics at each center. Public Health personnel will come out to the center to give immunizations and to assess for Medicaid eligibility. In addition, EPSDT clinics are beginning in February. These health services are usually available only in other areas of the city and have not been this accessible, so this represents a major cooperative effort by the Public Health Department (Ethnographer Report, Site J, February 1991).

The development of written agreements rather than informal "handshake agreements" was not always an easy process but eventually was accomplished by all grantees.

Through the institution of formal relationships between agencies, it is hoped that a structure will remain in the community at the end of the project. The presence of a formal interagency agreement implies that agencies will assume a more "responsible" role with regard to providing CCDP families with services, both during the course of the project and, hopefully, after the project is completed.

CCDP projects have implemented three different types of agreements in their efforts to coordinate service delivery to families. The first kind of agreement used by projects is a **Contractual** agreement. This agreement is formalized by a written document that outlines the provisions made by both parties. A contract specifies the services, including duration and type, to be provided to the program or to program families. It includes a fee for services to be rendered and is signed by an official of the agency providing services to the CCDP project. For example, many CCDP projects have contractual agreements for child care, in which projects pay child care providers for a given number of child care slots.

Projects also have developed **Cooperative** agreements with some community agencies. A cooperative agreement is a formal, written interagency agreement that generally has been signed by both parties, usually by senior staff members of the contributing agencies. The agreement generally contains information about the services to be provided and the tasks to be performed by the agency and by the CCDP project and specifies the duration for which the given tasks or services will be provided to families. Cooperative agreements are usually those for which no fees or expenses are incurred by the program for the receipt of services or support.

The third form of interagency agreement is the **Referral** arrangement. A referral agreement is any kind of arrangement that allows the project to refer clients to a particular agency. This agreement generally is not written. Many of the projects with established referral arrangements have identified contact persons at the agencies in their communities to facilitate the process by which CCDP families receive services. Under a referral agreement, the contributing agency might specify that it will refer clients to the CCDP project for

potential recruitment. The referral agreement indicates that the referring agencies support the CCDP project's goals and wish to contribute to program efforts. In some instances, the referral agreement specifies that cross-referrals (between CCDP and the agency) will take place.

CCDP projects have interagency agreements of all three kinds. Based on preliminary information available from 22 projects, it was evident that during the startup phase, the kinds of relationships established between CCDP projects and agencies in the community were more often cooperative than referral or contractual. Figure 14 on the following page demonstrates that of the 200 interagency agreements, 65 percent were cooperative agreements, 28 percent were contractual agreements, and 8 percent were referral arrangements.

CCDP projects develop agreements with a variety of agencies to secure core and other services. Among 200 agreements analyzed, 34 percent were in the area of health, 24 percent were in the area of adult education and training, 22 percent concentrated on services for children such as child care, 10 percent were with social services, and 9 percent were for services to assist with administration and staff training (see Figure 15 on the following page).

In future years, service data from the MIS will provide information on the extent to which specific services are provided directly by the CCDP project or through referral, cooperative, and contractual agreements. Data also will be available on the costs of these services and the financial contribution to CCDP made by these agencies.

Program Startup: Becoming a "New" Organization

The development of the internal organization, the CCDP project itself, also was a challenging and complex undertaking. It required accomplishing a number of difficult and time-consuming tasks. It also necessitated recognizing and addressing some differences in interpretation of the purpose and philosophy of the program as interpreted at the Federal level and as implemented locally.

A review of quarterly reports, site visit documents, and ethnographer reports indicates the most salient challenges of the projects.

Some of these major tasks included:

- Recruiting families;
- Locating and obtaining space;
- Hiring and retaining staff; and
- Understanding and modifying the program philosophy and practice to be consistent with Federal guidelines.

Recruitment of Families

Recruitment of families for the projects was a complex process requiring various methods across sites. In quarterly reports, ethnographer reports, and site visit reports, recruitment of families was noted as a problem for at least 54 percent of the projects. Efforts had to be targeted to eligible families—those under the poverty line, with a pregnant woman or infant under 1 year, representative of community ethnicity and teenage pregnancy rates, and living in the defined service area. Further, projects had to recruit three times the target number of program families to enable random assignment to program, comparison, and replacement groups; projects had to persuade families to sign up even though they might not have been selected to be in the program, but might have been assigned to the control or replacement groups. Projects were required to have reached full recruitment by September 1990.

Projects had to demonstrate in their proposals that adequate numbers of eligible families lived in the service area, but finding enough families proved difficult for almost one-half of the projects.

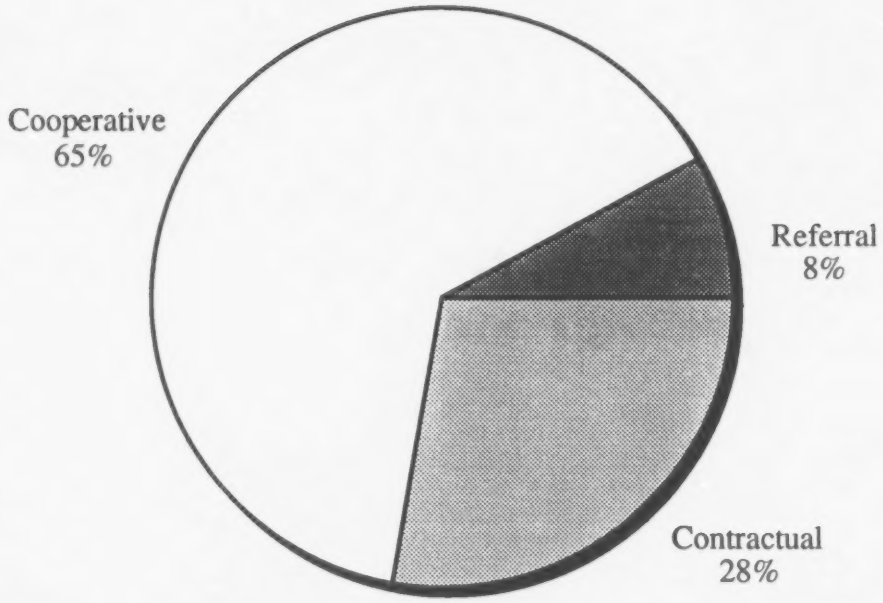
When the complexity of the task is considered, it is understandable how recruitment of families could be a problematic startup issue. At many sites, the process might best be described as one of "trial and error." That is, a sound plan was outlined, but as the process unfolded some methods proved more successful than others, and effort and strategy were adjusted. Even recruitment processes that appeared to go smoothly had to adapt some strategies. Grantees used a variety of methods as described below, and almost all relied on the cooperating agencies in their communities for assistance. For instance, one site ethnographer described the multitude of methods used at her site, highlighting their success:

> [Staff members] got word out to agencies in as many ways as possible. Their media campaign included public service announcements on radio, interviews on numerous radio shows and in various county newspapers as well as newspaper ads. They created a [project] newsletter that was sent every few months to [a number of] county agencies and individuals who might know of eligible families....Flyers were mailed...to all [social service] recipients with a child under one or a baby on the way. They were also enclosed in "new baby" packets at hospitals. And, of course, they were posted all over the [area]—in general stores, laundromats, health clinics...thrift stores, supermarkets and so forth. [Project] staff even went to the town clerks office to check birth records....[And] [t]here was a great deal of personal contact....In...May, for example, [staff members] attended eight preschool and kindergarten screenings and visited seven WIC and well child clinics and several area child care programs....[T]he director spoke with faculty in two area high schools and helped organize a social service luncheon attended by many area agencies... (Ethnographer Report, Site E, October 1990).

However, in an area where the number of families recruited was low initially, the same project described above had to make a special effort in recruitment by relying on the knowledge of the staff members. Referring to one of these areas, the site ethnographer notes:

> One [staff member] who is a native of that area described her efforts to me....[S]he began by calling or visiting people she already knew to find out about potentially eligible families....Altogether she estimated that she contacted as many as 180 people either through

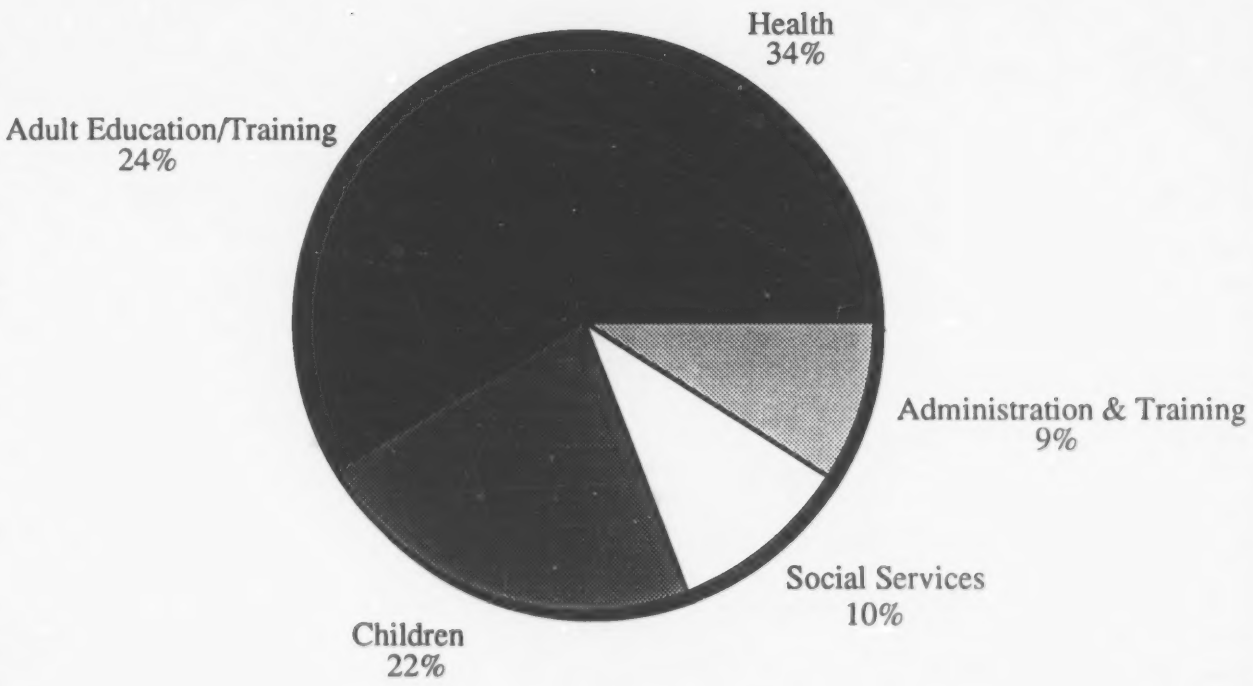
Figure 14
Type of Interagency Agreements



N=200 Program Families From 22 Projects

#09191

Figure 15
Interagency Agreements by Service Category



N=200 Program Families From 22 Projects

#09191

> home visits, telephone calls...discussions in stores, post offices and the like...[S]he recruited about 25 families, although not all were qualified to join (Ethnographer Report, Site E, October 1990).

Compare the above case with family recruitment efforts at another site. At this project the plan was to use a public agency serving poverty families as a referral source for potential clients. But concerns about using this agency were raised by the project staff because the agency had an unfavorable image among families served by it. It was, however, a major umbrella agency that would be able to identify most families relevant to the CCDP project. Eventually, the agency decided it would not release names and addresses but could provide a letter on CCDP to new enrollees and allow CCDP project staff members to meet clients at the agency's enrollment sites within the CCDP project's area. In the end, as the site ethnographer stated:

> ...(d)oor-to-door recruitment, initially designed as a supplementary recruitment strategy, was favored by most project staff and became "the major priority....A reorienting and redirecting of priorities was initiated at that time: (1) door-to-door recruiting; (2) [other local] agency referrals; and (3) staff time and resource issues,"... (Ethnographer Report, Site D, July/October 1990).

Overall the key factor in successful recruitment seemed to be personal contact. Although fliers and publicity helped, the human touch was required for actually convincing families to join, as described below.

> The plan entailed an initial contact by the recruitment team to briefly explain the program and leave an informational flyer. It was then up to the interested family to take it from there and to get back in touch with [the project]. After that an appointment with a case manager was scheduled who actually enrolled the family in the project. The community organizer in [one site] reported that often when they returned from their daily canvassing efforts, two or three people had already called. This experience was not, however, repeated in the other two sites. While people showed initial interest in the project, very few got back in touch to set up another visit and to actually enroll. Therefore, the [project] staff shifted the approach and began themselves to follow-up on potential project participants. This might be someone who expressed interest or just someone whom recruiters noticed was pregnant or had a young child. The recruitment process became much more active and interventionist. Eventually, people were being signed up on the spot with the program being explained by the case managers who were going out on recruitment efforts too (Ethnographer Report, Site N, October 1990).

In the sites described above, there was some practical work required to modify and adjust the strategies for recruiting families—perhaps more so at the second site described. Family recruitment was a pivotal aspect of program startup, in that through the recruitment process the project defined and confirmed its very reason for being. It is reasonable to assume that family recruitment was also the most uncertain agenda item across project sites in terms of predicting the results of methods used.

In addition to being an implementation activity involving untried methods, family recruitment also was a startup area requiring direct involvement and oversight by the Federal funding agency and its contractors. Specifically, the eligibility of recruited families had to be

verified by CSR using data on the families recorded by sites on recruitment forms specially designed for this purpose. Recruitment forms were completed on each family to collect the following information: number, names, ages and ethnicity of family members; existence of a pregnancy; and household income. Projects randomly assigned families to the three groups using a procedure developed by CSR. The data collected on recruitment forms were submitted to CSR for checking of eligibility, random assignment, and demographic representativeness of the community. After approval, projects recontacted the families to notify them of their group assignment and to enroll them. There were some delays in developing the forms, which impacted on some projects' recruitment because the contract for MIS development and the project grants were awarded in late September 1989, allowing no lead time for MIS development before projects started.

One project director's conclusion regarding family recruitment methods used at his site are consistent with descriptions at some other sites. His perception also highlights for his site the points regarding the uncertainty of recruitment method. As this project director put it:

> A...piece that became a barrier was the lack of availability of the MIS System which held us up in terms of starting to recruit families. The [family] recruitment step required some very specific kind of training. We clearly had proposed some things that we would do in our proposal. Some of those things worked very well. Some of them didn't work at all. The one that seemed not to work, for example, was posting flyers and brochures in various places. We got almost no families who responded on that basis. Personal contact turned out to be the best way to recruit, and the process of doing the training and the recruiting was delayed because the MIS wasn't there (Ethnographer Report, Site A, October 1990).

Despite the difficulties, recruitment did proceed, aided by the extension of the Federal deadline for the recruitment of all families and permission to use replacement group families to fill the program and comparison groups to facilitate full enrollment.

Space

Locating, renovating and licensing space for offices and child development facilities were challenges at nearly 60 percent of the projects. Often feeling they were moving "two steps forward and one step back," most projects secured permanent space by the end of the first year, but in many sites it was somewhat makeshift or crowded, as the ethnographers report below.

> Efforts to obtain and set-up office space have taken a great deal of time and energy, and the lack of space has delayed the progress of certain aspects of the project. As an initial step, [the project] rented office space in a new building a few doors down from the [grantee]. In order to make the space serviceable, file cabinets and other furniture had to be ordered, telephones installed, etc. As more staff were hired, the space became inadequate, but plans to acquire additional space next door, which were occupied by another department of the [grantee], were delayed when the completion of the new [grantee] building was delayed.
>
> The next-door space became available in September, but [the project] is still in the process of renovating it to meet its needs which include room for a large meeting area; storage room for toys, books, and infant supplies; and a small, private area for psychological counseling. [The

> project] has hired a space consultant for advice on how best to use its now expanded space in the original building, but the consultant is temporarily unavailable due to medical reasons (Ethnographer Report, Site K, October 1990).
>
> Site development has been a continuing process. During the Fall, [one] site was warm and welcoming and the [second] site was a sea of mud and construction materials. Now that the [second] program site has been remodeled, the [first] program seems crowded by comparison, and [the project] is working to get additional facilities on that lot. The third site is a temporary one, and the search for a permanent home for that program is continuing. (Ethnographer Report, Site U, February 1991).
>
> The project was initially housed in the office of [the grantee], in one large room. It became apparent with the hiring of three Family Development Specialists, in January, 1990, that more space would be necessary, and the five staff members were housed in a mobile home owned by [the grantee] and located 8 miles away. The mobile home was later moved to the edge of [town] in a mobile home court, where space was adequate if not luxurious. There was a problem with leaking propane gas, however, which affected staff productivity because of the length of time it required to get it repaired.
>
> The main office in the mobile home is now crowded. With the addition of an office manager, the hiring of three coordinators whose offices are in the mobile home, and six more staff, this is a total of six who are officed full-time in the mobile home, plus eight field staff who regularly visit the office, and the ethnographer.
>
> There are now four field offices; while this relieves the pressure on space at the main office, there is still no conference room. Staff meetings have been conducted in the city hall and in the homes of the two coordinators. In addition to the shortage of conference or meeting room space, there is also no space in the main office for private interviews unless someone's office is free (Ethnographer Report, Site X, October 1990).

Some sites experienced several moves during the first year of operation, an occurrence that would clearly consume energy and time available to the development of first year activities. At one project, the site ethnographer notes that:

> [A]ccording to Project Managers obtaining adequate space has been one of the major barriers to implementation. The Project started out sharing the [other local agency] office which is located in a local public school, moved to a small cluster of rooms in [a local hospital], and finally secured space for most of the staff in a privately owned [area] office building. The original plans were to obtain space large enough to house the entire [Project] staff, nursery, and other activities, but the cost of such a site was considered prohibitive. [Project] staff are currently housed at two locations (Ethnographer Report, Site C, October 1990).

Clearly, obtaining space was not the only agenda item for a project during the first year. Projects also were hiring staff members, recruiting families, and developing their programs and the coordination of services. One site ethnographer summarized the multiple activities at his site, noting that:

> ...(D)uring this period the project director and administrative staff continued their search for space in which to house the administrative offices and child care facility. After several months of discussion and negotiation with [Agency One], a community social service project, an impasse was reached. Subsequently, negotiations began with [a local school district] for

> temporary housing for the administrative offices and permanent housing for the child care and educational facility. Simultaneously, discussion was begun with the [Agency Two] for housing for the Administrative offices....During this period both recruitment and hiring of staff continued, as-well-as the continuation of meetings with service organizations in the catchment area. A program of staff training for the case managers was begun....In June staff moved into the catchment area and were temporarily housed in three classrooms in the [local elementary school]....By June 30th, 101 families had been recruited....In July, negotiations were completed and arrangements made with [Agency Two] for permanent program offices and the staff moved into this space in late August (Ethnographer Report, Site B, October 1990).

Staff Hiring

Recruiting, selecting, and hiring a cadre of qualified, committed staff members to provide the services and the administrative support necessary proved a challenge for 59 percent of the projects. In many cases job descriptions were unfamiliar and somewhat amorphous. The families to be served were very poor and had many problems, and the communities to be served were low income and often dangerous.

> Staff recruitment was a continuous and difficult process. The objective was to attract candidates who were both qualified and willing to assume a new and uncertain position. The positions also required a dedication to work in low-income communities with extremely disadvantaged and at-risk families. The project was ultimately able to recruit capable, qualified and committed staff. The problem of retaining staff who were required to work in a complex and stressful environment has been an ongoing task for the project (Ethnographer Report, Site W, October 1990).

Recruiting staff at all levels proved difficult in some sites, as well as locating staff members with special credentials and abilities.

The task of hiring the direct service staff members who would interact most closely with the families generated considerable thought and effort.

> First, there was an attempt to hire as many indigenous workers as possible or at least to hire people who were familiar with the community. This often meant a concerted effort to reach beyond the usual avenues for advertising job openings. Phone calls were made to other local service agencies and information about the positions was passed along via word-of-mouth and various community-based channels of communication. It also meant that, during the selection process, previous involvement with the community counted as important educational and job experience. For example, the Community Organizer in [one site] had had no formal training for this position, but was hired because of her lengthy residence in the community and her previous work as president of a [community group]. Second, there was also consideration given to promoting people who were already employed in the host agency in each community and who thus had experience in working together and in performing roles similar to those they would be undertaking in the....project. Finally, there was consideration given to factors such as race and gender that it was felt might enhance people's ability to relate to and work with project families without, however, discriminating on the basis of such factors (Ethnographer Report, Site N, October 1990).

> Family advisors are clearly the backbone of [the project]. Some of them have made great sacrifices to work for [it]. For example, two of the male advisors took considerable pay cuts

> and left jobs that gave them more financial security and some of the women are very experienced in community and family work and have an excellent understanding of the area served by [the project]. Most of the family advisors, in age and experience, may expect to be in a higher paying position at this stage in their lives. Some are single parents with child care needs and could use many of the services [the project] seeks to offer families, yet they are not available to family advisors (Ethnographer Report, Site M, October 1990).
>
> The process of recruiting and hiring Family Advocates has been a long one, started in May 1990 and not yet finished. Even though the process of finding appropriate Family Advocates (and, indeed, all staff) is quite time consuming, the project has made the commitment to put their efforts up front in screening and hiring individuals who will facilitate the project goals, rather than facing the potential consequences later when staff leave dissatisfied because of an inappropriate match (Ethnographer Report, Site D, July/October 1990).

Staff Turnover

As might be expected in a new program and certainly in a new human service program with a high level of complexity, there was some staff turnover during the first year. According to quarterly reports and correspondence, overall staff turnover was 17 percent and ranged from none in two projects to 59 percent in one project.

Turnover of four or more staff members during the first 18 months occurred in 54 percent of the projects. In 45 percent of the projects at least one case manager/family advocate resigned or was terminated. In 27 percent of the projects the case management coordinator left. Also in 27 percent of the projects, the project director left during the first 18 months. Both project director and case manager positions were vacated at some time during the first 18 months in 18 percent of the projects.

Lack of Understanding of Requirements

Difficulties emerged during the first 18 months due to the lack of awareness of the CCDP concept and some specific Government requirements for its implementation. For example, many project directors did not realize that all core services had to be available for all program families needing them or that they would be required to pay for these services if the family were not eligible for subsidies. This created problems in areas for which projects had underbudgeted, such as child care and health care for adults. The need to conduct developmental screenings and assessments and to provide developmentally appropriate early childhood educational services to all preschool children on a regular basis was not clear to projects initially.

Federal requirements were clarified on a site-by-site basis as site visits occurred during the year and with periodic correspondence to all sites. Although site visits were stressful experiences for some projects, the visits served to clarify expectations as well as to provide the Government representatives and management support contractor staff with a realistic view of the demands faced by the projects on a daily basis. As will be described in greater depth in Chapter 3, Section F, Site Visit Findings, the great majority of the problems identified on site visits were resolved.

For example, a project that was experiencing serious problems due to lack of leadership and turnover in senior positions had appointed an acting director only weeks prior to the site visit who was beginning to take action on the problems. As the ethnographer reported, "Vigorous activities to achieve compliance were already in place by the time of the site visit. The site visit served to clarify the compliance problems and to mobilize concentrated and specific actions to correct them" (Ethnographer Report, Site E, February 1991).

Differing philosophies about the purpose and operation of CCDP also arose. Differences existed both between the Federal Government and the projects as well as within the projects themselves. One recurring difference was the Federal perspective that family self-sufficiency was one of the primary goals and that some efforts should be directed toward that end in a planned manner, including the development of family needs assessments, the establishment of family service plans and goals, and the provision of services to meet those goals. Some projects saw this as conflicting with the empowerment of families and also with the immediate need to respond to family crises. Other projects believed that both foci could be addressed simultaneously. This dual emphasis was supported by the Federal perspective.

One ethnographer quoted a family worker who reflected "a widespread feeling" that:

> You could say we are confused....At first, the talk was about empowerment and making families their own best advocates, building strengths and making less of personal liabilities, all that....But then, we hear more and more talk about getting people off the welfare-rolls and into the pay-rolls. And that's ok, I guess, but to me empowerment means more than that; it means taking time to educate people and making up for all the information and interpersonal skills they didn't get when they were growing up....And that takes time, you can't do it in two months....So the program started out looking like, yeah, real new; and now it looks more and more like the regular social worker approach to case management (Ethnographer Report, Site Q, February 1991).

The tension between responding to immediate needs and more long-term planning was also noted.

> Yet another aspect of this early phase has been a constant need to respond to grave and immediate needs on the part of the participating families, while at the same time, trying to implement appropriate tasks for individual and collective capacity building among adult participants without neglect toward children who constitute the focus of the program (Ethnographer Report, Site Q, October 1990).

Other projects had a goal-oriented philosophy from the beginning and had few problems with it.

> Families report that outlining the goal obtainment process into specific achievable steps helps them to believe that the goals can be achieved and that goal achievement is not an overwhelming process (Ethnographer Report, Site R, February 1991).

Staff Becoming Operational

Some of the differences identified in the previous section were resolved over time as projects and staff members began to "settle in" to their programs. As staff members became more accustomed to the uncertain nature of the day-to-day work, became more familiar and comfortable with their roles, they increased their flexibility to respond to multiple tasks with less tension and confusion.

> [The staff members] frequently have the feeling of "pioneering," of setting out procedures that no one else has attempted. This process was described quite graphically in an interview with one staff member:
>
> > There is a need for individual initiative [on the CCDP project]. We have the outer edges of the puzzle [for most of our project tasks] and some lines, like the trees and the water. But there is still much that the person has to add. To succeed in this type of work, you have to be proactive, not reactive. You have to hire people who want to work like that....
> >
> > The analogy could be like someone setting out on a journey. To do so, they need a compass and someone to say "Go West." I think [one staff member] was looking for someone to show her the road, and the fact is that there is no road. At least, not yet! (Ethnographer Report, Site A, October 1990)
>
> A second process-oriented barrier created by the previous roles and associations, however, is what large organizations call "position or job jettison." Letting go of the old and familiar ways of operating and perceiving situations in favor of embracing new procedures, new relationships and new perceptions presents an obstacle for the field personnel to overcome. Their former roles in both their organizations and their communities have been fairly well-defined for years and their challenge has been and will continue to be to realign both their own self-image and the communities' perception of them in their new positions (Ethnographer Report, Site S, October 1990).

Some projects made special efforts to promote "team-building" among their staff by bringing in consultants for this purpose, holding staff retreats, and sponsoring staff social events. One ethnographer quotes a CCDP staff member on the process of building a workable team of staff:

> This is real life not some kind of bureaucratic dream! You can't expect complicated people who have strong feelings about the community and about the families, and who have problems themselves, to come together without some tension. But that's what's good about the whole thing; we've given people permission to be themselves and to fight and grow even in spite of themselves. So there is tension but there is also a lot of hope, and most of the time we get along and we get the job done (Ethnographer Report, Site Q, February 1991).

The end of the first 18 months of operation did not bring an end to all the startup problems. For some projects these continued well into the second year. However, by the late spring of 1991, 20 months into the program, most projects had moved past these issues and were devoting their efforts to program operation and service delivery.

SERVICE DELIVERY CHARACTERISTICS

Case Management Models

The use of family focused case management is a critical variable in providing intensive, comprehensive, integrated, and continuous support services to CCDP families. Case managers are responsible for building relationships with the families and provide, coordinate, and/or monitor the services that are necessary to carry out a set of goals established by the family. The case manager serves as a coordinator of the services delivered. Major activities or the manager include screening/intake; development of a family needs assessment; development of a family service plan; crisis intervention; implementation of the family service plan, which may involve brokering, advocacy, supporting, problem solving, and/or providing the services; monitoring; and evaluation. In many CCDP projects, the case managers also provide home-based early childhood education services, training to adults in areas as parenting skills, health and nutrition, and other educational interventions.

In addition, due to the CCDP research component, case managers must be regularly involved in data collection activities. Besides gathering requisite information that is crucial for the process evaluation, regular collection of information about services that family members are receiving enables case managers to monitor the progress being made by the families and to continually assess their ongoing needs.

Based on information available at the end of 18 months, there is an average of 7 case managers at each of the CCDP projects. The projects identify the staff person providing case management services with different titles, such as home visitor, family advocate, family consultant, family support worker/coordinator, family advisor, family service provider, family care coordinator, parent educator, family partner, and family development specialist. Regardless of the title used, the roles and responsibilities of the persons carrying out the case manager role are similar to those described above.

Not all the grantee agencies had previous experience with providing case management services. Forty-two percent of the sponsoring agencies had extensive experience with case management (e.g., in operating family support, self-sufficiency, or teenage parent programs), while 38 percent of the sponsoring agencies had previous experience with only some case management services (e.g., needs assessment, referral, etc.). Twenty-one percent of the grantee agencies had little or no previous experience with case management.

Characteristics of CCDP Case Management

Case management approaches

Most of the case management approaches and methods used by the grantees use strategies were conceptualized as being based on the family support/family education model. This model is based on several assumptions, including (1) services provided to families are determined by the needs of the parents and are responsive to the cultural and social characteristics of the communities in which the families live; (2) services provided should build on the strengths that whole families and individual family members already have; and (3) services should increase the family's ability to cope rather than provide a system on which families become dependent. Most of the approaches and methods emphasize the concept of family empowerment, that is, family members are expected to be active rather than passive participants and assume decisionmaking power in terms of making choices and defining the services they wish to obtain.

Structure

Twenty-one of the twenty-two projects reviewed have a generalist structure of case management. In this structure one individual within the staff relates to the family and coordinates all components of the service delivery for that family. Within the generalist structure, the coordinating person may use different members of a team to provide specific services. Most of the projects using a generalist model also used different types of teams to supplement the work, for example, during the home visits, for supervision during staffings, in the development of the family service plan, etc.

One of the projects uses a specialist structure for case management in which staff members work together as a team, with each member providing a specialized component of the total service delivery plan (i.e., substance abuse, health, assistance with income support). Within this structure there is no one person who has overall case management responsibilities for a given family; instead, the responsibilities are shared by many staff members.

Table 3 on the following pages provides a description of the use of teams by the different projects.

In the majority of sites (57 percent) the responsibilities of providing early childhood education and case management are performed by the same individual. At these sites a major challenge for staff members is learning how to balance the case management and early childhood tasks. One ethnographer describes this role as follows:

> [P]robably most powerful is [the Family Consultant's] function as an organizer and impetus to take action on goals set. With the regular schedule of visits and the very thorough Family-Based Support Plan, the Family Consultant's visit serves to break up time into discrete and manageable portions for the client. The family has to somehow account for what action they took on correcting identified deficiencies, on working with their children on development

> activities, on improving their own situation. And that impetus, applied consistently, is of major value to these families (Ethnographer Report, Site A, February 1991).

The complexity of balancing multiple roles is reflected by the following comments of a case manager who carries out both case management and early childhood functions:

> ...But in most cases there's a lot more to discuss than whether or not to use a pacifier or why isn't the baby sleeping through the night. Even on my first visits I was inundated with questions about AFDC, child support payments and WIC, as well as problems with alcohol abuse and domestic violence. It's difficult to do an art project with a preschooler if Mom's worried about how to stretch the food for the rest of the week. Needless to say, I've been getting an education on how the "system" works so these families can get the services they're eligible for. (Project Newsletter, Site E, Spring 1991).

Many of the sites (43 percent) separate home-based early childhood education from the case management role. In these sites, one person provides overall case management and another person conducts home-based early childhood education activities. This means that each family has frequent contact with two project staff members: one staff person who deals with case management issues, and another who has regular contact with the family to model and teach developmentally appropriate activities to the family/child. When the case manager and home-based early childhood education roles are split between different persons, greater teamwork and communication are imperative for integrated service delivery. Both staff members must be clear about their respective roles and recognize the reciprocal effect of their own role on that of the other, thus accepting their mutual responsibility for each family. The site described below has found several advantages in its team approach, which utilizes a family advocate to focus on early childhood education and a case manager who works with the family on goal attainment and linkage to services.

> Another advantage of the [site] model is the team approach that is actively fostered by the differentiation and then linking of the case management and child development components. Some have raised questions about having two persons go into the homes of families. Does this feel intrusive and overwhelming to the family? While these concerns need to be taken seriously, reports from [the project's] sites are that families do not seem to find this a problem and may actually prefer having two individuals with whom they are working and to whom they can turn for various needs. In fact, in many cases, families themselves seem to use the team in a creative and interesting way. For example, they may raise certain topics in a more personal, or "gossipy," way with the family advocate, setting the groundwork for dealing with a serious family issue with the case manager. Or they may discuss a possible course of action with the case manager in terms of family goals and the service network and then use the family advocate as a sounding board to try out alternative perspectives, develop their own thinking, or deal with some of their contradictory feelings about the matter. The whole...project is built around the idea of collaboration and team-work. The case management/early childhood development model attempts to bring this overall programmatic goal down to the day-to-day working of the staff and into the homes of the service families (Ethnographer Report, Site N, April 1991).

On the other hand, several issues may arise when different staff members are working with the same family. There may be concern among members of the team about information that they may lose about a client in a team structure, which dilutes their primary contact with

Table 3
Case Management Teams

SITE	USE OF TEAMS IN CASE MANAGEMENT MODELS
I	Two teams, each comprised of a developmental specialist (supervisor) and four home visitors, are used to perform both the case management and the child development functions. Also, the developmental specialist does the initial child development assessment and develops the plan with the home visitor; the home visitor then carries out this plan.
C	Three teams are used. Each team includes a case manager who is a social services specialist, a parent educator who is responsible for the child development component, and a home visitor who gathers information and identifies problems. The parent educator and home visitor make weekly home visits together and share information with the case manager, who provides guidance. Teams meet weekly. One team leader coordinates all three teams.
K	Two types of teams are used. Six family care coordinators (the case managers, including three who are bilingual and three who speak only English) and their case management coordinator form one team, which meets monthly for group supervision. In addition, two case staffings are held weekly (one with bilingual coordinators and one with English speaking coordinators), each of which includes three family care coordinators and five specialists: the employment coordinator, parent education coordinator, early childhood coordinator, case management coordinator, and a physician.
V	A specialist approach to case management is used, whereby families are referred to the appropriate specialist at the project, rather than having an individual case manager. Specialists include parent educators, social workers/counselors, a physician, an early childhood specialist, a recreation worker, a male coordinator, and center managers. The team of specialists meets weekly. Currently the project is reorganizing to allow these specialists to take on a caseload of families and to introduce home visitors, who will assume the early childhood function. The specialists/case managers will continue to meet weekly, and the home visitors will be included in these meetings.
L	Teams are used at both sites and include four case managers, their coordinator, and home visitors (early childhood). Each team meets weekly, and both teams meet monthly to staff cases. Case managers and home visitors work closely as a team but visit homes separately. The case managers are to become more specialized with regard to the type of families with whom they work; some will work only with families in crisis, while others will focus on the area of education/training and family needs after stabilization.
E	Three types of team meetings are used. Every 6 weeks a home visitor (case management and early childhood) teams with a multidisciplinary group comprised of the director, family service coordinator, early childhood coordinator, nurse, psychologist, and educators, to review the home visitor's entire caseload and record plans for the families. The same team may be called together any morning by any one of the team members to deal with a crisis; personnel from outside agencies may be called upon to attend these meetings. All staff members also team with a consulting psychologist for a monthly problemsolving session. At this meeting challenging families are discussed, and an action plan for these families is devised.

Table 3
Case Management Teams (continued)

SITE	USE OF TEAMS IN CASE MANAGEMENT MODELS
N	Several teams are used. Each site has a neighborhood team, which includes the neighborhood coordinator, two case managers, two family advocates (early childhood), a drop-in center worker, child development specialist (supervisor of the family advocates), and a driver. In addition, case managers and family advocates visit the home separately but work in pairs. The case managers, family advocates, child development specialist, and neighborhood coordinator meet weekly to staff cases. Case managers from all sites meet with the project director biweekly to discuss cases and data collection.
G	Family support advocates (case management and early childhood) may team up with one of the project's coordinators (family relations, education/job training, and day care/child development) to meet with the family, if needed. All project staff members participate in monthly case staffings. Family conferences are held as requested by the advocate; these conferences involve the family, the advocate, the case management supervisor, and relevant coordinators.
J	The family team leader (case management) may team up with any of the project specialists (career manager, nurse, child development manager, center director) to meet with the family, as needed. Every 6 months, the family team leaders, parent(s), child development manager or center director, relevant specialists, and relevant community agency staff members team up to staff all cases individually.
F	Case coordinators (case management and early childhood) may team up with a family support worker (mental health) or child development consultant to meet with the family, if needed. The project operates out of two centers and holds weekly staffings at each, which are attended by the case coordinators, center director, and family support worker (mental health) based at that center. Each case coordinator also teams up with his/her respective center director for weekly individual conferences in which the case coordinator's entire caseload is staffed.
A	Family consultants (case management and early childhood) may be accompanied on a home visit by a project specialist at the request of the family or the family consultant. These specialists include: child care specialist, economic self-sufficiency specialist, preschool director, men's issues specialist, and parenting education director. Three types of team meetings take place: (1) weekly staffings of one or two families by their family consultant, the family consultant coordinator (supervisor), the project administrator, relevant specialists, and the family, as appropriate; (2) bimonthly group staffings of one family, including all family consultants, their coordinator, and the project administrator; and (3) weekly group brainstorming/training sessions, involving all the family consultants, their coordinator, and the project administrator.

Table 3
Case Management Teams (continued)

SITE	USE OF TEAMS IN CASE MANAGEMENT MODELS
B	Case managers (case management and early childhood) may team up with the core services coordinator to meet with the family for problemsolving/information sharing. The education director also teams with case managers on a rotational basis to oversee and facilitate provision of the home-based early childhood activities. The case managers team up with the educational director, medical director, nurses, core services coordinator, parent director, and sometimes the project director for weekly staffings of families. At each staffing, participants review one case manager's entire caseload, and other families are discussed as needed for problemsolving. Meetings of the child care center staff, a nurse, and a case manager are held weekly to discuss children in the center; case managers participate in these meetings on a rotational basis.

a client. The following example illustrates this by presenting the thoughts of a supervisory team member who monitors the educational/training goals and has monthly contact with families who are followed more intensely by a home visitor on a weekly basis.

> Personally I enjoy the contact with my clients, the partnership that I have with them. If they've got a [home visitor] working with them also, I feel that it will help them in a lot of areas where we cannot go out to do those home-based things that they need done, like taking them to doctor appointments or things like that. But yet I feel ambivalent in that area. Because if this person, the [home visitor], gets to run around and do all those things with them and really become their friend, that person is who they are going to depend on.... (Ethnographer Report, Site H, April 1991).

Issues of understanding and adapting to role differences also arise in teamwork and are described by one ethnographer.

> The team approach to case management is an exciting one, but making it work is much more difficult than using a single case manager from one practice tradition. Many program implementation problems have resulted from the difficulty of blending differing disciplinary traditions and backgrounds on the teams. The difficulty in recording family plans is not just a "form training" problem; it also reflects differences in the backgrounds of the team members which are so ingrained as to seem "natural" and "just the way everyone does this" (Ethnographer Report, Site U, March 1991).

The Use of Community Members as Staff

As part of their commitment to recognize and respect cultural traditions and the values of the community, several projects used individuals indigenous to the community served and with less than a college education, often referred to as paraprofessionals, to provide the case management services. Important criteria for the selection of nonprofessional case managers included life experiences that mirrored those of the target families, experiences as teen or single parents, indigenous to the community, and a history of substance abuse. These staff members were valuable in serving as liaisons with other resources, as well as in acting as outreach workers to families in stress. Although extensive inservice training was provided, in practice tensions resulted between the beliefs and practices of these staff members, and the requirements of specialized training to deal with multiproblem families.

In many instances programs had to revise their commitment to use paraprofessionals, and during the initial implementation of all projects, ACYF recommended that a minimum A.A. educational level be required for case managers.

Supervision of Case Managers

The responsibilities and duties of the case manager supervisors vary by site. In some sites the supervisor's responsibilities are focused primarily around supervision of the case managers, while in others the case management supervisor also has major administrative responsibilities such as managing a center or acting as assistant director of the project. Information available at this time indicates that over 50 percent of case manager supervisors

have a post-college degree, 26 percent have a college degree, and 13 percent have some college education (see Figure 16 on the following page).

Supervision is provided through a variety of mechanisms. All projects provide some type of formal group supervision, which most often takes the form of a weekly staffing of cases. One-quarter of the projects noted that they provide individual supervision in addition to group supervision. In several projects, different types of group supervisory meetings are held; for example, one of the rural projects uses biweekly family team conference meetings in which various types of staff discuss one particular family and its family service plan. In addition, there are monthly Family Updates in a Nutshell (FUN) meetings in which one manager and a multidisciplinary team meet to discuss the manager's entire caseload. Finally, there are Coordination of Services (COS) meetings, which can be called by any team member to discuss an immediate or crisis situation; relevant persons from the team and community are asked to attend. At another rural project, the case manager and supervisor meet twice a month; the early childhood staff, case manager, and supervisor meet twice a month; and all case managers working in the five counties meet monthly as a group.

Aside from formal types of supervision, some projects indicate that additional supervision is provided as needed; this may be informal or formal, may occur around a crisis situation, and may be available on a daily basis.

The case management supervisors may have staff members other than case managers whom they are supervising, so their supervisor-supervisee ratio may in actuality be greater than the ratios stated above. Areas for future analyses include the relationship between level of the case manager's education and variables such as the number of managers per supervisor and the types and amount of supervision.

Activities of the Case Manager

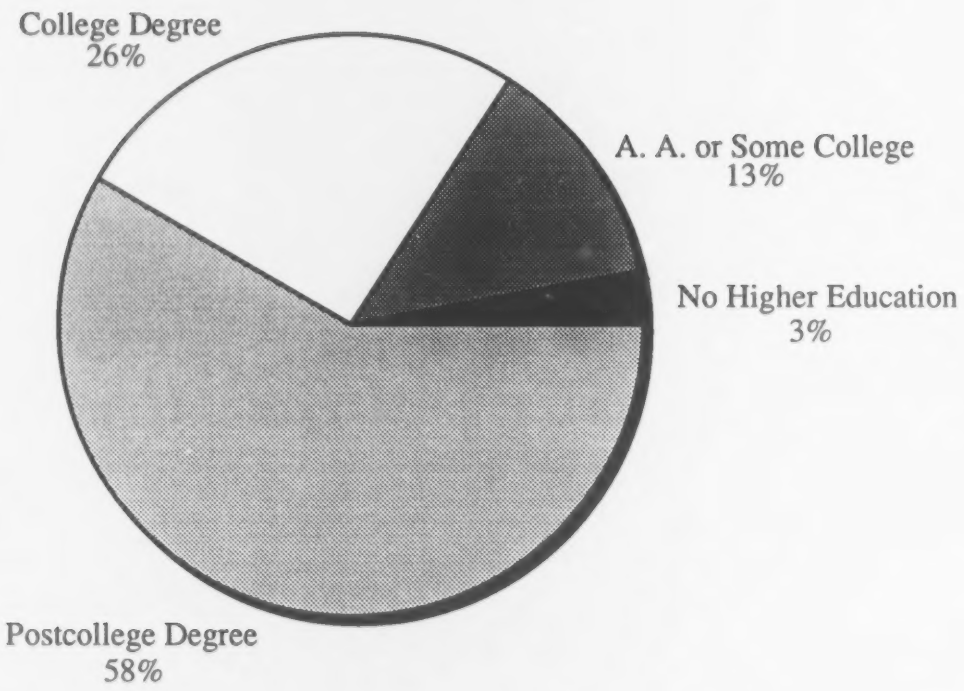
Frequency of home visits

Data on frequency of home visits were only available on the 12 site visits that had been conducted. More than three-fourths of the projects reported that staff members were making home visits at least every 1 or 2 weeks. Better documentation and verification of this frequency needs to be made through future MIS analyses.

Caseload size

It is recognized among programs utilizing home visitors that caseload size has a direct impact on the number of home visits that can be made each month. Among the 11 projects visited that used the generalist model, the number of families assigned to each manager ranged from 8 to 30, with an average caseload of 16. Most case managers have between 13 and 21 cases, with 19-21 being the most common range. Figure 17 on the following page displays the caseload sizes for the 11 generalist projects that had site visits during the first

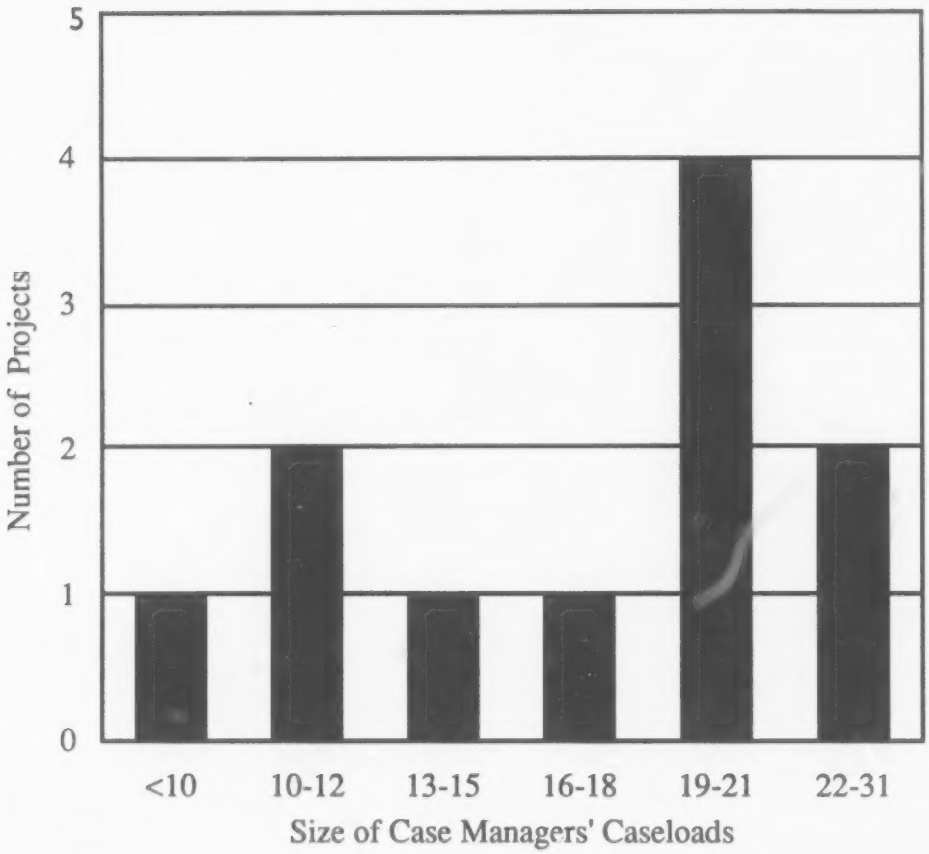
Figure 16
Education of the
Case Managers' Supervisors



N=23 Projects

#09191

Figure 17
Case Managers' Caseload Sizes



N=11 Generalist Projects Visited

#09191

fiscal year. Most of the projects with caseloads of more than 20 lowered them to less than 20 after the site visit.

Family needs assessments

Gathering information for a family needs assessment is one of the essential tasks of the case manager. The quality and extent of the information gathered in this assessment determines many of the activities which are to follow.

All of the projects use some type of family needs assessment. The simplest involve use of the MIS Family Assessment form as a guideline. However, most projects use additional assessment forms, either their own or standardized instruments/scales or a combination of the two. For example, one project uses a Family Strengths and Needs Assessment, which covers child, adult, and family domains and includes guidelines for 13 key areas such as family coping strengths, family relationships, and family support networks. Another project uses a combination of their own Family Resource Assessment and the following tools: Home Observation of the Environment (B. Caldwell), Difficult Life Circumstances (K. Barnard), Community Life Skills Scale (K. Barnard), and the Teaching and Feeding Scales (University of Washington School of Nursing). Some projects use their own form in combination with instruments developed by Carl Dunst and his colleagues, such as the Family Needs Scale, Support Functions Scale, Resource Scale for Teenage Mothers, Family Resource Scale, and Inventory of Social Support.

Because the CCDP projects are multidisciplinary in nature, additional assessments in specific areas such as health/nutrition, employment/training, and early childhood education are often a part of the assessment process; these additional assessments may be done by the case manager or, more often, by specialists. In fact, some projects allow for the comprehensive nature of the assessment process by conducting first a general assessment, as the case manager works to stabilize the family's situation, and subsequently a more comprehensive assessment, after the results of the specialized health, employment, and early childhood assessments are received. Assessments are updated periodically.

Family service plans

As goal attainment will be a key process variable in the analysis, the process of needs assessment, developing a service plan and documenting the goals, is a basic process within CCDP. The family service plan is based on the family needs assessment. It is a written document developed by the case manager and family that usually includes the following types of information: resources needed, prioritization of goals, actions to be taken, roles family members will play, timeframes, client involvement or lack of it, and evaluation of the extent to which needs have been met.

All of the projects utilize a family service plan. The development and review of this plan is critical for three reasons: (1) the plan provides an organizing structure; (2) the plan breaks goals down into discrete attainable steps that build upon one another; and (3) the plan

makes family members, the case manager, and other staff members responsible for specific actions.

The majority of the projects specified that the family was involved in this process, either by receiving a copy of the plan, signing the plan, or attending a team meeting to discuss the plan. Several projects specified that a team conference (which may or may not include the family) was a part of the process in which family plans were developed or reviewed.

Most projects have a specific form(s) on which family plan information is documented. One project in the Midwest uses the following three forms: (1) Goals: Short- and Long-Term; (2) Goal and Action Plan; and (3) a Quarterly Review of Progress and Efforts Toward Goals. This project also has organized information on adult needs/goals around the CCDP core areas. Another project uses an Individual Action Plan for family members as well as a Family Action Plan.

Because specific goals and the activities required to attain these goals are constantly changing, it is critical to review and update each family's progress and goals periodically. Thirty-eight percent of the projects specified a timeframe for the completion of the family service plan, ranging from 1 month to 90 days.

Crisis intervention

It was apparent at several projects that were visited in 1990 that much of the startup work with families involved crisis-oriented activities. Prior to beginning work on a service plan for the family, including parent educational or vocational training or working on a child development experience in the home, there were basic crises that needed to be addressed first. These crises ranged from the threat of eviction to lack of food, imminent cut-off of utilities, domestic violence, and acute alcoholism. As described by one ethnographer:

> One reported frustration is in not being able to deal with the long-term problems. One family consultant reports at least two of her assigned families are "chronically in crisis," having to deal with immediate problems, like the threat of the electric power being shut off, when other problems with long-term impact, like training for the husband or wife to obtain a better job, remain unresolved (Ethnographer Report, Site A, October 1990).

The *Federal Register* specified that families be provided with assistance in securing adequate income support, health care, nutritional assistance, and housing. For projects located in major urban areas, the housing crisis causes case managers to spend much of their time trying to locate available housing units for families. During the startup period, case managers at several projects had difficulty moving beyond the crisis issues facing families and working on issues like parent classes and vocational training. There is a delicate balance between crisis and long-term needs. While it is important that families not be forced to set goals before they are ready, it also is important that the case manager not allow crisis situations to cause lengthy delays in setting these goals. The housing crisis has been described in some detail by one ethnographer:

> Blacks in [the city] face a housing crisis in all of its dimensions: limited quantity, poor quality, extremely high costs, and limited access. Poor families depend heavily on public housing which is in disrepair and highly segregated. Recently [the city's] chief housing inspector was quoted in the [newspaper] as saying "Words cannot describe how bad it is over there." The inspector was referring to the conditions in a 700 unit housing project from which some families were recruited for CCDP.... The housing projects and the areas surrounding them are plagued by drug use and violence. Drugs and violence are probably the most difficult problems facing the neighborhoods served by [the CCDP project] (Ethnographer Report, Site M, October 1990).

The information that has been presented in this section of the report provides a picture of the basic structure of case management in the CCDP projects based on descriptive, qualitative information available at this time. The MIS will provide more detailed information about case management at each of the sites, which can be used in future reports to address the process of case management as well as specific issues involved in case management practice. The next section will cover the delivery of the core services to families.

Core Services

The following sections describe the strategies projects use to deliver core services in early childhood education, chid care, health care, parent education, adult education, vocational training, mental health care, and assistance in obtaining income support.

Early Childhood Education

Under the guidelines for provision of core services, all CCDP children under compulsory school age must receive a developmental screening and assessment. In addition, children must be provided with developmentally appropriate early childhood educational experiences. These experiences may include developmental programs for children provided in centers (CCDP sponsored, Head Start, and other programs), home visits, or a combination of home- and center-based activities. In center-based programs, teachers and aides provide the intervention. In home visits, the intervention focuses on the parent or other child-caring person in the context of the parent-child dyad. The expectation is that the parent will continue the intervention through activities in the days between home visits. Parents receive training in infant and child development, as well as parenting, in planned group educational sessions, in resource centers, and during home visits. In some cases, parents participate in parenting activities in the early childhood centers by observing and/or participating in the classroom activities.

The Head Start Performance Standards (to which CCDP projects must adhere) require that the educational experiences be ones which stimulate physical, cognitive, emotional, and social development. An optimal learning environment should be provided to foster cognitive development through problemsolving, exploration, communication, and concept development.

Some programs mainstream children experiencing developmental delays in their centers or home-based model. Other programs provide or refer children for specialized early

intervention services. These services include activities performed by the regular teachers or by teachers with expertise and special training in early intervention, and the activities may be carried out in the center or in the home. Some programs have specialists on staff to work with children who have hearing, speech, emotional, social, or physical delays.

Screening and assessment instruments and early childhood educational curricula

CCDP projects have adopted different screening and assessment tools and curricula to ensure that the early childhood experiences they provide are appropriate for children's developmental levels. Projects often selected several well-known curricula models and adapted them to their families, program philosophies, and staff expertise. Table 4 on the following page lists the number of projects using various screening and assessment tools. The table also displays the number of projects using various curricula and the number of projects making use of each curriculum. As is evident from the data in Table 4, some projects are using more than one screening or assessment tool. Similarly, there are projects that have adopted more than one early childhood curriculum. At the time this information was obtained, the most frequently used screening tool was the *Denver Developmental Screening Test II* (used by nine projects), and the most frequently used assessment tool was the *Hawaii Early Learning Profile Instrument* (used by six projects). The most frequently used curicula are the *Hawaii Early Curriculum*, *High Scope*, and *Small Wonder*.

Child Care

Child care is a mandated service under CCDP guidelines and is a crucial service in terms of its effects on both child development and parent employability. CCDP projects provide child care to families when a parent is working or involved in training. Child care must be state licensed or registered and meet Head Start Performance Standards if it is the only early childhood experience for CCDP children. It may be provided to parents who request it for respite or when the court has ordered child care for child protection. Projects also provide child care when it has been clinically determined that a child needs a center-based group developmental experience. In such cases, projects may provide families with child care through a developmental day care or a part-day developmental preschool program. Data are not yet available on the number of projects making use of early intervention programs or on the number of children enrolled in these programs, but these data will be captured in the future by the MIS.

Shortly after CCDP grants were funded, it became apparent that most CCDP sites had underestimated the problems inherent in the provision of child care as they prepared their grant applications. Since the award of the CCDP grants, the problem of finding and funding adequate and affordable child care slots for CCDP children has grown in importance and has become a major issue for some sites.

Basically, the child care problems that have emerged since the award have been the following:

Table 4
Early Childhood Education Models
Screening and Assessment Instruments and Curricula

Screening and Assessment Tools	No. of Projects	*Curricula*	No. of Projects
Denver Developmental Screening Test II	9	Hawaii Early Learning Curriculum	9
Hawaii Early Learning Profile Instrument	6	High Scope	7
Learning Accomplishment Profile	4	Small Wonder	7
Early Learning Accomplishment Profile	4	Local school/county curricula	4
Battelle Development Inventory	4	Active Learning	1
Brigance Diagnostic Inventory of Early Development	2	Good Beginning.	1
Early Screening Inventory	2	Creative Teachings in Early Childhood	1
REEL (Bzock and League)	2	HIPPY	1
Bayley Scales of Infant Development	1	Partners for Learning	1
Transdisciplinary Play-Based Assessment	1	Portage	1
Infant Monitoring Screening Tool	1	Nuevo Amanecer	1
Infant Mullen Scale	1	Banana Briefs	1
		Native American Curriculum	1
		Parents as Teachers	1

- Many projects underestimated the immediacy of the need for child care among participant families.

- Projects did not make adequate provisions in their first year budgets to allow for the purchase of a sufficient number of child care slots (for example, they overestimated the availability of subsidized child care slots).

- Projects were, in many cases, unaware of the inadequacy of the child care reimbursements.

- Many communities lacked an adequate number of child, particularly infant, care slots to ensure their availability.

- Some projects were unaware that many State and locally approved facilities did not meet CCDP standards.

Underestimation of the immediacy of need

As reported earlier, CCDP projects served 4,158 children under age five, including 2,455 less than 1 year old. As the parents of these children became increasingly involved in the programs offered by CCDP (e.g., basic skills classes, English as a Second Language [ESL] and General Equivalency Diploma [GED] classes, support group meetings, and other preemployment activities) parents requested quality child care more frequently. Furthermore, more parents than expected were ready to enter the employment market. Anticipating that such requests would arise in later years, projects were not prepared to meet the request.

Staff members at one of the projects voiced their concerns about the lack of adequate, appropriate, and affordable child care:

> ...[C]hild care is currently an overwhelming issue, partially because of the tremendous lack of it within the areas the project services, and partially because it's mandated by [the Federal Government]. Transportation is another big issue, however it is not one that requires as immediate a level of attention as child care (Ethnographer Report, Site D, October 1990).

Some sites discovered that many day care facilities included in their original plans were inaccessible to families due to inadequate local transportation systems. One site indicated that its alternative strategy for increasing the number of available child care slots in the face of transportation problems (i.e., encouraging families to offer home care) turned out to be equally unfeasible as the cost for home improvements and provider application fees required by the jurisdiction created a financial burden on prospective providers.

Inadequate budgeting

Many sites did not budget sufficient funds for the provision of child care. An inspection of Year 1 budgets indicates that sites allocated from $5,500 to $300,000 for this purpose, with a median allocation of $7,400.

As CCDP projects became more actively engaged in project-related activities, many realized that they had to pay as much as $125 a week for infant care and as much as $90 a week for toddler care. One site on the east coast found that it was obligated to purchase 40 child care slots from a local provider at a cost of $8,000 per child per year for a total of $320,000. Projects were hoping that child care block grants would be available and that they would be able to link with Federal programs such as JOBS. This, however, met with limited success.

Another problem faced by many projects is that they anticipated that State and county reimbursements would defray major parts of their child care costs. As projects made child placements, they discovered that the reimbursements did not cover the costs involved and that they are responsible for the large differential. As child care facilities often charge up to $125 a week for their services, State and local reimbursements defray only a fraction of this fee with reimbursements ranging from $9 to $11 a day for infants; less for toddlers. In some States, reimbursement funds became totally unavailable due to State budgetary problems aggravated by the recession.

As many of these costs were not calculated into the original budgets, many sites were not able to be in compliance with this requirement during their first 18 months of operation (see Chapter 3, Section F, Summary of Site Visit Findings).

Inadequate supply of child care slots

Five grantees provide onsite child care for a limited number of families; 1 grantee has access to 20 child care slots in a center operated under the auspices of its umbrella agency. Of those programs that must purchase child care slots from community providers, one grantee indicates that it has access to "some" child care slots, and four grantees indicate that they are making "continued efforts" to locate appropriate spaces for the children of CCDP families.

The remaining 13 sites are experiencing various degrees of success in locating child care slots in communities in which the needs of working parents are placing great strains on an already taxed child care system. Only two of these sites indicate that they are having no difficulty in meeting emerging child care needs.

Inappropriate facilities

In at least two States, project directors indicate that State standards for granting approval to child care facilities, which focus largely on the assurance of child safety, are not adequate for the needs of CCDP families. In these States, inspections are conducted quickly, and there are no mechanisms in place to revisit sites to ensure that standards are being met over extended time periods.

In one of these States, efforts currently are under way to offer incentives to those day care programs that are attempting to improve the quality of care being offered. This State is examining the desirability of increasing reimbursements to providers that encourage staff

members to enroll in training activities that will provide instruction in child behavior and child development activities.

Solutions to the problem of child care

Several projects have developed innovative mechanisms for alleviating their child care problems. Most of the mechanisms involve the process of enlisting local families to provide day care in their homes for a nominal fee or restructuring the CCDP site so that limited care may be provided onsite for program participants. Solutions that have been identified include the following:

- Developing additional subcontractual arrangements with child care agencies;
- Employing a staff member to train families to participate in the child care system by serving as family day care providers;
- Providing monetary and technical assistance to those parents who demonstrate an interest in becoming family day care providers;
- Defraying fees involved in registering and remodeling the households of families willing to provide care;
- Purchasing a large number of slots at a lower than normal rate to defray costs;
- Negotiating arrangements with the local departments of education to provide child care in school facilities to allow teenaged parents to continue their educations;
- Employing the services of a child care consultant to develop practical arrangements for the care of young children;
- As a temporary measure, paying family relatives to care for children;
- Enlisting grandmothers to volunteer their time to provide onsite, short-term child care; and
- Applying for local grants earmarked for the development of improved child care arrangements.

For several projects, the lack of available child care services in the catchment area resulted in the development of CCDP child care centers. A child care center was established at one of the rural sites through the collaboration of community agencies; the center provides core services to children as well as their parents. As described below:

> One cannot discuss the current service delivery system of [the project] without mentioning the [child care] center that opened at the High School. It was a collaborative effort between the

> project and the Career Education Center, and its planning committee included members of many other agencies, such as the Department of Health.... The project's interest in this child care center developed out of its experience in the recruitment process; since almost a third of project parents turned out to be teens, it became pivotal to find a way to help them finish high school. The child care center generated considerable publicity for the project—most of it favorable—and gave a boost to recruitment efforts that were underway at the time (Ethnographer Report, Site E, December 1990).

Health Care

Each project has developed a model for delivery of health care services that includes provision of prenatal, routine and acute care, health screening and assessment, and immunizations and other preventive care. The models developed differ widely with respect to their structure for services provision and staffing. The differences often are dependent on the type of grantee agency, the availability of and proximity to community health care providers, and the working relationship between the grantee and local health care providers.

Routine/preventive care

All projects have developed linkages with clinics or medical centers to provide routine health care for CCDP clients. These health providers usually are located in close proximity to the families they are intended to serve, and in several cases the CCDP projects are located in facilities owned by a clinic or medical center with which the projects are contracting for health services. Other projects have had a collaborating health agency set up a clinic or offices for individual clinicians (such as a nurse practitioner) onsite at one or more of the project's multipurpose centers. Projects have established these arrangements to facilitate the provision of multiple services; for example, families can stop in to discuss case management issues on the way to or from a health appointment or can utilize project drop-in child care during their appointments.

One-half of CCDP projects also have established linkages with private physicians to maintain consistency for families that had been seeing a provider before CCDP began and, whenever possible, to respect families' preferences. Linkages with clinics or physicians often consist of written agreements stating willingness to collaborate, responsibilities of both parties (e.g., transportation, completion of forms), and assurances of confidentiality and may include provisions for information sharing between the health providers and the project to facilitate case management functions with the family. To quickly identify a patient as a CCDP participant (and thus party to the terms specified in the agreement), several projects have introduced the use of a program "card" that families carry with them when visiting a health provider in the CCDP network.

Projects also are concerned about families receiving continuity of care, so that chronic health problems can be identified and treated accordingly. One project has addressed this issue by focusing on establishing a "medical home" for each family. The project is trying to identify a primary physician for each of its families, a person who will be able to track the health of family members in a consistent manner. Although this project has established

agreements for the provision of routine and acute care with several medical centers in the area (including the grantee agency center), approximately 50 percent of the children in the project currently are being seen by community physicians.

Provision of health care by agencies or persons outside of CCDP is supplemented in many cases by systems developed within CCDP. Twelve projects have a health specialist such as a doctor, nurse, or medical director either directly employed by the project or assigned to the project through a contractual agreement. These persons may supervise, coordinate, and/or provide direct services (such as screenings) for the health component of the CCDP project. For instance, the coordinator of medical services at one project is a pediatrician whose responsibilities include maintaining communication with major area health providers, meeting with the home visitors weekly, and reviewing charts and providing consultation and recommendations regarding individual family members.

Five projects provide some health services in home visits. Four of these projects are rural sites and use home health visits instead of transporting families long distances to receive routine or preventive care. The purposes of these home visits range from conducting health screenings and compiling a medical history of the family to providing prenatal care and monitoring the overall health conditions and practices of the family members. Three of these projects have arranged to have public health department nurses visit families. At the other two projects, a health coordinator makes home visits periodically to conduct health screenings and to collect information on family members' health histories/conditions. One project has assigned public health nurses an important role both in monitoring families' health care needs and in coordinating the case management provided through home visits, as the ethnographer describes below.

> The relationship between [the project] and the Public Health nurses is probably the most complex of the subcontractor relationships. This is because the Public Health nurses are the conveners of the Family Resource teams, which are the heart of the project. The nurses work for the project but they also continue to work for the Public Health Service. This means they fill out double paperwork, so their activities and clients can be represented in both systems. Once a month, they meet with [the project director] and the two family center coordinators and with their Public Health supervisors to discuss the case management component of the project. In addition, they meet with the supervisors in Public Health to discuss the health aspects of their...cases (Ethnographer Report, Site U, February 1991).

The health specialist visiting the home in all cases provides only preventive or routine care and coordinates referrals to other health care settings for treatment of acute health care problems.

Acute health care

All projects have developed contractual or referral agreements with hospitals or local public health departments to ensure that children receive acute health care when necessary. However, it has been somewhat more difficult to establish a service delivery system to meet adults' health care needs, particularly in the area of acute health care provision. Although

most CCDP adults are eligible to receive medical care through their participation in Medicaid (or their State's equivalent), a number of families have members who are employed and may be ineligible for Medicaid. As a result, the role of the CCDP case managers may include that of assisting uninsured adults in locating cooperating physicians who will provide them with services on a "no cost" basis.

Parent Education

As a holistic program that focuses on the many needs of low-income families, CCDP is committed to providing a well-rounded agenda of educational activities to improve families' abilities to care for themselves and especially for their children. Parent education may occur in the family's home or in a group setting. Topics defined as parent education include instruction in child development and child rearing issues, health care instruction, and nutrition counseling.

In-home education

Most parent education activities are provided in the home by the home visitor. This setting allows for parental education to be provided in a nonthreatening environment and facilitates one-on-one instruction from the home visitor. Home visitors provide instruction in parenting and in child development while they work with the parents and CCDP children, and visitors encourage parents to raise issues of specific concern to them. (See early childhood education section for more information.)

Topics relating to nutrition often are discussed in the home as the home visitor discusses with parents the eating habits of their children and other family members or assists in the preparation of a nutritious meal or snack. Programs vary in the degree to which they emphasize nutrition education in homes, often depending on staff expertise and training.

Topics related to the health of the child and the family as a whole may be raised during home visits as the home visitor works with parents and encourages and assists them in visiting health care practitioners for routine visits and immunizations for their children.

Out-of-home education

Parent education also occurs in group settings regularly scheduled at project facilities or other community agencies. Professional CCDP staff, consultants, and specialists from other agencies conduct educational and/or support group sessions on a range of topics from child development to nutrition to job-seeking skills.

Nutrition education, for example, often is provided by the county extension agent or a health department nurse who works with the project under an interagency agreement to provide nutrition training in specially convened parent groups. This offsite training has the advantage of allowing specialists to supplement their presentations with audiovisual support and hands-on experiences.

Adult health and general health issues usually are discussed in clinic settings. As parents attend clinics for routine visits for themselves or their children, providers take the time to provide CCDP families with instruction about healthful practices and behaviors and make recommendations for health improvements in their lifestyles.

Adult Education

In support of the CCDP goal of assisting CCDP families in achieving economic and social self-sufficiency, projects offer a wide array of adult education programs. These programs provide training in the following: literacy, basic skills, skills for daily living, and ESL. To build on educational resources in the community, projects have developed several arrangements, including complex referral networks, to ensure that families' educational needs are adequately served. These referral arrangements are negotiated with community colleges and other local educational institutions that already are serving the community.

Four projects provide adult education in-house and have hired specially trained staff members to conduct ESL classes for family members and/or have contracted with local colleges or the county extension agents to train CCDP staff to provide instruction in basic living skills. This allows project families to receive instruction through the project, often from staff members they already know.

Vocational Training

Several resources exist in the communities to provide vocational training to project families. These include community colleges, high schools, vocational centers, State employment and training facilities, departments of social services, and JTPA grantees. The services provided by these resources vary greatly, particularly with respect to client assessment and counseling and placement assistance. The services also vary greatly with respect to availability. Projects that rely on JTPA for vocational services, for example, often cannot assure placement slots for their clients at the end of the fiscal year, as JTPA grantees await re-funding.

Only one project provides vocational services directly through the project. The remaining projects rely on a combination of interagency agreements and referrals to place clients in appropriate vocational training settings. In one midwestern site in which many families are interested in the development of small businesses, the project has signed a contract with a small business development specialist who is prepared to provide "entrepreneurial training" to those clients who express an interest. In the course of his training, this specialist provides intensive assessment and counseling to clients who work with him on a one-to-one basis over extended time periods.

Mental Health

Mental health support generally is provided to families through interagency agreements with local mental health centers or private mental health agencies. Services provided by these agencies include individual and family therapy, marital counseling, and treatment for

dysfunctional or aberrant behavior. Persons with more serious problems are referred to inpatient treatment facilities.

Three projects report that they have the resources to provide support for mental health issues directly through the program. These three projects, located in regions where migrant workers constitute a large proportion of the body of clients, thus are able to react quickly to client problems and crises that often emerge as a result of highly stressful lifestyles.

Substance Abuse

Most projects respond to family needs due to alcohol and drug abuse through interagency agreements with drug and alcohol treatment centers, health centers, and alcohol rehabilitation centers to provide intensive counseling and outpatient care. Eleven grantees have signed agreements for these purposes; others are in the process of negotiating agreements. Site visit interviews revealed a low incidence of drug abuse but a high incidence of alcohol abuse in rural communities. Case managers report that low-income families in isolated communities tend to use alcohol in larger than expected quantities to replace the social interaction that is more accessible to city dwellers.

Three projects that provide substance abuse counseling in-house through the expertise of staff nurses raise questions about abusive behavior but send family members to more specialized facilities for indepth counseling and treatment.

Income Support

Most CCDP families are eligible for several forms of income support, including Aid to Families with Dependent Children (AFDC), food stamps, and Medicaid. The provision of this assistance is characteristically the responsibility of the State Department of Social Services. Most CCDP projects have formalized their relationships with these agencies, thereby facilitating client access and encouraging communication between the CCDP project and the welfare agency. For example, some agencies have agreed to designate specific staff members to serve all CCDP families to avoid the problem of families getting "lost" in the system. However, in other projects, agencies have felt that they must treat all clients equally and not make special provisions for CCDP families. In these and in the sites in which CCDP families receive special attention, CCDP project staff members frequently serve as advocates for families to facilitate their receipt of the services to which they are entitled.

Transportation

The requirement that projects ensure adequate transportation is available for families to access all core services became a major difficulty for some of the grantees, especially for the rural or very isolated sites. Furthermore, many grantees did not understand fully the implications of this requirement or did not anticipate the extensive transportation needs of families.

Projects are making transportation available to families by providing tokens, hiring cabs, or reimbursing staff for providing transportation in their own vehicles. Many of the projects have purchased or leased one or more vans and have hired, usually part-time, drivers.

Staff driving families in projects located in expansive rural areas are using the "driving" time to conduct case management activities. This became a problem in some sites where case managers were spending a large amount of time driving families.

ATTRITION

Attrition of families and children has been a recurring problem in early intervention and family support program research (Consortium for Longitudinal Studies, 1983; Weiss and Jacobs, 1988). It is a factor that will be monitored closely in the CCDP demonstration in future years. Unfortunately, because of the delay in the implementation of the MIS, attrition data on *enrolled* families were not available for this report. However, data were available on attrition of *recruited* program and comparison families from summaries prepared by grantees for the impact evaluator, Abt Associates, which compiled these figures. Attrition figures presented here are based on the number of families originally recruited who were lost, refused participation, or were dropped (due to ineligibility) between the time of being originally notified of assignment to program or comparison groups, and the time of enrollment.

Based on data from 22 projects, of 2,398 families recruited and assigned to the program group, 213 or 8.9 percent were lost or dropped, and 133 or 5.5 percent refused participation. Of the 2,329 assigned to the comparison group, 198 or 8.5 percent were lost or dropped, and 97 or 4.2 percent refused to participate. The combined attrition from families lost, dropped, and refused varied across sites. The highest total attrition rate at a project for program families was 56 percent. High rates also were found in three other projects with 37 percent, 31 percent, and 23 percent attrition. Five sites had no initial attrition.

The findings were similar for families assigned to the comparison group. The highest attrition rate at any site for the comparison group was 51.7 percent, whereas the lowest rate was 0 percent; there were seven sites with no attrition in the comparison group at the time of enrollment. The attrition rate at the time of enrollment was higher for the comparison group than for the program group at six sites. Attrition was higher for the program group at nine of the sites. Attrition was the same in both groups at seven sites.

SUMMARY OF SITE VISIT FINDINGS

Each year the Federal Project Officer and CSR and ITI staff members visit each grantee at least once. The site visits have the following purposes: to allow the site visit team to become more familiar with the operations of the project; to monitor the implementation of the MIS; to determine if CCDP grantees are in programmatic compliance with their proposals and Federal requirements, including the provision of core services; to collect data for the

process evaluation; to provide technical assistance when needed; and to identify grantees' concerns.

Information in this report covers the first 12 sites visited. During these initial visits, projects had been in operation between 9 and 14 months and had been serving families between 2 and 6 months. During the 3- to 4-day site visits, extensive interviews were held with project staff members and with representatives of agencies providing major support to the project. Site visitors observed home visits, center-based child development programs (including early intervention, Head Start, and day care programs), parent education classes, and an advisory board meeting. Focus groups were conducted with parents and case managers/home visitors. In addition, MIS procedures and data were reviewed, and administrative and service records were reviewed.

Following the visit, site visitors prepared two reports for the grantee project director to summarize their observations. The first, the post-site-visit letter, summarized the strengths of the project, areas of noncompliance with program requirements, and program areas in which improvement was needed. The letter included a list of items to be addressed in the grantee's action plan, which is prepared in the response to the letter. The second report, the site visit report, provided an overview of the contextual issues faced by the individual project, a detailed summary of the core and noncore services provided, and a description of the project's efforts to integrate services already being provided in the community.

This summary of site visit findings is based on the observations made during the site visits and reflects those issues that were raised in the post-site-visit letters and in the site visit reports. For the purpose of this report the issues of concern were grouped into the following inclusive categories: CCDP program administration, core services for children, core services for adults, case management, and administration of the MIS. Each of these categories of issues is presented across sites.

The sections below summarize the analysis of site visit observations at 12 sites by delineating the major strengths and programmatic issues identified in the site visits. The section entitled "Strengths" includes those areas in which projects had an outstanding or innovative mechanism in place to carry out program objectives; the section entitled "Programmatic Issues" addresses areas in which program weaknesses were noted. In sum, this analysis of these early site visit reports suggest some of the major issues—both strengths and limitations—existing in the beginning startup phases of the projects. The section also includes findings on the largely successful efforts of the grantees to remedy these problems after the site visits.

Strengths

In response to the Federal mandate concerning CCDP operation, grantees have developed programs that are highly individualistic. These programs reflect each grantee's desire to make the project responsive to the needs of the target community and to the

ethnic/social background of its population, while using the existing community infrastructure to provide needed services and support.

The following sections summarize those areas in which projects were found to excel during their first year of operation. Those issues that were noted as strengths in six or more of the projects visited are included in the discussion.

Program Administration

The grantees visited appeared to be having their greatest success in the area of program administration. Post-site-visit letters document that all of the programs were commended on their selection of staff, indicating that program staff members were well qualified for their positions and exhibited a great commitment to the project and its families.

Additionally, many programs had developed close working relationships with their grantee/umbrella agencies. These relationships allow projects to rely on the grantee agency for assistance in program planning, for guidance, and, in many cases, for administrative staff support. In some programs, the CCDP staff is represented on host agency committees, allowing for a collegial relationship to be developed between the two. This supportive relationship, which was cited as a program strength in six of the sites, often allowed the CCDP project to have more credence in the community, an important element when networking among service delivery agencies for support.

Although child care arrangements negotiated by the projects generally were inadequate to provide enough child care slots to meet the needs of program families (see "Programmatic Issues"), the child care facilities identified to serve the families appeared to have been well chosen. Six projects were informed by site visitors that the facilities in which they had chosen to place program children provided a safe environment, well-qualified staff, and good care. In four of the six projects cited, this care included the provision of developmentally appropriate early childhood experiences.

All hardware and software needed for the operation of the MIS were in place at seven projects at the time they were visited. Lastly, six projects had reached their recruitment goals at the time of their visits. These projects often received recruitment assistance from the local departments of human services, Head Start programs, county departments of health, and other community agencies providing services to program families. In addition, the projects benefitted from community-wide public relations campaigns that encouraged families to contact the CCDP in the area to learn of the services that it could provide.

Core Services for Children

Of the core services provided by the projects for children, CCDP projects appeared to be having their greatest success in providing for the delivery of health services. Seven projects demonstrated that they had put in place a strong program for the provision of routine health care, including the routine immunization of children for childhood diseases. Six of

these same projects also had a well-defined program for the provision of acute care services to children.

Core Services for Adults

The core service for adults provided with the most consistency across projects was prenatal care for pregnant women. Nine of the projects were found to have good mechanisms in place for the provision of prenatal care. These project mechanisms included providing prenatal services onsite, discussing birth and delivery issues during home visits, and/or encouraging the case manager to monitor the pregnant women's attendance at prenatal visits.

Case Management

In eight of the projects visited, case managers were commended by the site visit team for being "caring" and engendering positive feelings among program families. Parents in attendance at parent focus group sessions indicated that very good rapport existed between families and the case managers, and families felt that their case managers were personal friends. The performance of case management was, however, not noted as a program strength for any of the sites. (This issue will be further discussed in the section entitled "Programmatic Issues.")

Programmatic Issues

As described earlier, achieving startup in a complex project such as CCDP requires the simultaneous completion of numerous tasks. As noted above, projects were able to accomplish many tasks quickly and with a great degree of success. The completion of other tasks, including the delivery of a number of required services, consistently posed difficulties for projects visited during the startup period. As programmatic issues were identified at each site, projects took immediate steps to address problems and remove obstacles to service delivery. Projects reexamined their proposals and models of operation, streamlined organization, and actively researched and sought out resources and solutions to address the issues identified at their sites. The following sections describe programmatic issues observed in at least 50 percent of the projects at the time they were visited and how projects successfully addressed these issues.

Core Services for Children

Provision of the early childhood development experience

At the time of the site visit, seven projects had not completed the process of screening children for possible developmental delays. By the end of the startup year, five of the seven projects had completed all developmental screenings for preschool children, and the other two projects had completed most screenings. Early childhood specialists in those programs generally stated they had little guidance in the selection of appropriate screening instruments, that they were frequently uncertain of the distinction between "screening" and "assessment," and/or that they had insufficient time in which to complete this requirement. Less than one-

half of the CCDP projects had completed their child development assessments prior to the site visit.

In 8 projects, the site visit team noted that case managers had not yet developed individual child development plans for program children. When questioned about this deficiency, case managers indicated that they (1) were unaware that the plan had to be in a written format or (2) considered the program's statement of goals for all children to be sufficient for this purpose. However, by the end of the startup period, six of the eight projects reported that they had completed individual child development plans for all preschool children.

The failure to select and implement an appropriate early childhood curriculum to be used during home visits was perceived to be a problem in 11 of the program sites. Interviews with home visitors indicated that this problem may have been precipitated by various factors, including the lack of an available curriculum at the site, a lack of familiarity with the curriculum selected by the site, or the lack of supervision in the selection of appropriate curricula when multiple curricula were available. All of these projects reported having successfully resolved this issue by adopting an appropriate early childhood curriculum by the end of the startup year. However, in some cases, questions remained about how fully the curriculum actually was being implemented.

Six of the projects visited were not providing developmentally appropriate early childhood educational experiences either through home- or center-based programs. Additionally, staff members often were uncertain when asked by the site visit team about the required frequency or duration of the early childhood educational experiences to be provided. By the end of the startup period, four of these projects were providing developmentally appropriate early childhood experiences on a regular basis.

Addressing these issues and solidifying all aspects of the early childhood component required creativity and determination on the part of project directors, early childhood education coordinators, and home visitors. For instance, a site visit at one project found that developmental screenings on program children had not been completed, individual developmental plans for children had not been developed, the early childhood curriculum identified in the proposal was not in use, and early childhood experiences were not being delivered. After the visit the project candidly presented the results of the site review to the project advisory board and began conducting research and formulating plans for strengthening the early childhood component.

About 1 month after the site visit, the project finalized a plan of action outlining strategies and timelines for addressing the issues identified. The action plan stated that two research assistants had been hired to complete the screenings and had already begun to do so. The home visitors were working with the researchers and the families to schedule appointments for assessments. A new family service plan was developed that included a separate section to record each child's individual developmental goals. The project selected several early childhood curricula to be used with families, and the action plan reported that

the project had arranged for home visitors to receive 30 hours of training on one of the curricula. Timelines were established for completion of all activities planned.

Three months after the site visit, the project reported having completed the screenings and assessments using the *Denver II* and *Vineland* instruments. Home visitors had received 4 hours of training on how to implement the new family service plans and had developed an individualized developmentally appropriate action plan for each focus child based on the results of the screening and assessment. The plans included activities from the three curricula identified in the action plan for use in home visits. Home visitors had received 28 hours of training to use the *Parents as Teachers* curriculum; 4 hours for the *On BASE!* curriculum, which deals with building self-esteem in children; and 1 hour of training on a calendar that provides a suggested infant stimulation activity for parents to do with their children each day of the year. Training included education in child development, practice in developing early childhood development plans, and supervised home visits with certified *Parents as Teachers* instructors. The subsequent quarterly progress report noted that eight of the home visitors were to receive certification in *Parents as Teachers* based on their performance, attendance, and passing required tests.

A second visit to the project revealed that in addition to these items being completed, home visitors were writing plans for each home visit and leaving handouts for the parents to use between visits. Home visitors also were scheduled to receive an additional 20 hours of training on *Parents as Teachers* in the coming year.

Child care

As discussed previously, CCDP projects' arrangements for child care tended to be inadequate to meet the immediate needs of many families. Both a lack of funds for child care and an inadequate supply of child care slots in the community, especially infant slots, contributed to the problem. Data from the site visits indicated that 9 of the 12 programs had inadequate provisions for child care arrangements. Some of these programs were seeking alternative strategies for locating child care slots, including encouraging families to gain certification as family day care providers and negotiating preferential arrangements with Head Start agencies. However, these efforts had not been successful or completed at the time of the site visits, making the need for improved child care arrangements a continuing issue. Six of the nine projects had made acceptable temporary arrangements for the provision of child care by the end of the startup period, but longer term child care to meet the growing needs of families still needs to be resolved.

Oftentimes the resolution of the child care issue entailed the innovative use of extant resources to meet the child care needs of families. At one project, for example, a site visit determined that licensed child care was not being provided for all of the CCDP families needing it. The project was underbudgeted in the area of child care and had resorted to using relatives, neighbors, or friends to serve as child care providers. Most of the child care funds budgeted for this CCDP project were devoted to an onsite center providing child care to 22

children requiring early intervention services. The project was asked to develop a reasonable plan through which *all* families' child care needs would be met.

The project prepared an action plan approximately 1 month after the site visit, which indicated that all children receiving unlicensed child care would be placed in licensed settings. Three months after the site visit, a report was submitted indicating that the project anticipated a greater need for child care in the ensuing months and, consequently, was working on a plan to develop a 50-slot child care center in the community. Funding for the proposed center still was being explored.

A followup site visit was conducted 5 months after the initial site visit. At that time, the project had submitted a joint proposal with another agency proposing to set up the 50-slot center to the Job Opportunities and Basic Skills (JOBS) program in their state. Federal grant dollars still were reserved for child care slots at the early intervention program and subsequently could not be freed for other uses. Concerns about the availability of money to fund needed child care slots were expressed to the project, because there was insufficient permanent money allocated in the budget to meet the anticipated child care needs over the next few years.

Eight months after the first site visit, the project submitted a report demonstrating how they had worked to make use of existing resources and had developed strategies for tapping into other sources of funding to address the project's child care needs. The project had developed a daily billing mechanism to Medicaid as part of a therapeutic plan for each child such that all Medicaid revenues collected would be returned to the grant for programming use. At the time the report was submitted, 85 percent of the children enrolled in the early intervention center had a third party payment source for their daily care (Medicaid). The program anticipated that a substantial amount of Federal grant funds (as much as $175,000 per year), formerly reserved to pay for early intervention slots, could be freed up.

In addition to the reallocation of Federal funds to deal with burgeoning child care needs, the project had taken some active steps toward tapping into a $9.4 million block grant to be used by the State for enhancing federally funded child care programs. This money was expected to be available to the State in the fall of 1991. Project staff met with the commission that oversees the block grant and learned that funding would be accessed through a voucher system operated by the State's Department of Human Services. Furthermore, the project was able to enroll eligible 3- and 4-year-old children in Head Start programs, and parents entering education or job training from AFDC rolls were able to access transitional child care through the JOBS program. The project also was able to arrange for eligible CCDP participants to be targeted as a priority service group in the State's plan for use of Title IV-A monies.

Core Services for Adults

Completion of family needs assessments and service plans

Site visit reports indicate that nine projects had not completed the family needs assessments and an equal number had not developed family service plans to meet the identified family needs. The family needs assessments and service plans provide the framework for the provision of services to families. Consequently, this shortcoming impeded the delivery of the most appropriate and necessary services for families in a plan-oriented way that promotes progress toward self-sufficiency. All projects had completed the family needs assessments and service plans for all enrolled families by the end of the startup period.

One of the primary solutions developed by many of the projects to deal with problems involving incomplete needs assessments and service plans was to develop an organized and systematic record-keeping system for managing caseloads, which could be monitored and reviewed on an ongoing basis. For example, at one of the first sites visited, it was evident that family needs assessments had not been performed on all families and that family goals and service plans had not been established. It simply was recommended that needs assessments be completed and service plans be developed to ensure case managers could adequately monitor families' progress on their goals and assist families in obtaining the services needed to reach their goals.

In subsequent communication, the project provided written clarification with regard to family needs assessments and service plans. Case managers were completing family needs assessments within 90 days after a family had enrolled in CCDP and were utilizing a life skills assessment to aid in the process of completing the needs assessments. The assessment examined whether the family had any needs in the areas of financial assistance, employment, education and training, housing, transportation, health and nutrition, mental health, family interrelationships, parenting, and other needs. From the needs assessment, a service plan was developed. Case managers used a *family goals sheet*, which listed goals that family members planned to work on; a *family assistance plan*, used to describe the plan for addressing family needs and goals that the family chose to address; a *family goal attainment checklist*, used for reviewing the efforts made by the family in attaining each of its goals; and progress notes, which summarized case managers' activities with their families. Weekly team meetings were being held to review caseloads, and each family was discussed at least once per month to examine how the family was meeting its goals and to link the family with any needed services.

A second visit was made to this project approximately 11 months following the initial site visit in order to assess the project's programmatic progress. At that time, the project demonstrated that family needs assessments had been completed for all families using the Head Start Family Needs Assessment and that service plans had been developed as well.

Parent education

Planning and implementing parent education programs constituted another problem area for many of the 12 programs visited during the startup year. The data indicate that eight projects had not started to adequately address infant/child development issues during home visits. Six of these eight had adequately resolved this issue by the end of the startup year. Eight projects were not yet providing parenting skills training, and eight projects had not begun focusing on health care education during parenting sessions. By the end of the startup period, seven projects were providing parenting education in both of these areas. Further, seven projects were not providing nutrition education to parents; five of these had addressed this issue adequately by the end of the startup period.

Projects created and implemented various solutions and plans to address problematic issues surrounding their parent education programs. Many projects hired a parent education coordinator to arrange for parenting classes and speakers, to develop the curriculum, and to explore parents' educational needs and interests. For example, at one of the projects, a site visit indicated that the case management coordinator also was responsible for ensuring that parents were receiving education in areas of child development, health care, nutrition, and parenting. Because this individual was already overworked with other responsibilities, it was recommended that the project consider hiring an additional staff member to absorb the duties surrounding the parenting education program.

In its plans to address this issue, the project indicated that a parent education coordinator would be hired. However, considerable difficulties were encountered in identifying a candidate with the requisite skills and characteristics for which the program was searching. Five months after the site visit, the program submitted a report indicating that a parent education coordinator had been hired but was unable to begin work due to health problems. The project again began to search for a candidate to fill the position while the case management coordinator continued to perform the parenting education responsibilities. Almost 8 months following the site visit, the quarterly progress report indicated that the individual who had been hired 3 months prior had begun working as the parent education coordinator, and the project was extremely pleased with the individual's skills, talents, and ability to motivate families to participate; the message was conveyed that it was worth the delay to bring this person on staff.

Other projects experienced delays in getting their parent education programs under way because of issues involved with implementing the parent education through cooperating or interagency agreements with other agencies. For example, one project had developed an interagency agreement with the local city school district specifying that instructors would be provided to the project for its parenting education classes and workshops. The onset of parenting classes was delayed, however, because of difficulties in coordinating the details of this arrangement with the school district. The provision of formal parent education classes was delayed as well because there was no staff member to assume the responsibilities of coordinating the parent education program, such as selecting a parent education curricula to

supplement the programming that was to be provided by outside agencies, arranging for and planning adult education activities, and assessing parents' educational needs.

The project submitted a plan of action following the site visit which indicated that a social worker on staff had been assigned the duties of coordinating parent education and training. This staff person would be responsible for bringing together parent education curricula and training formats used by other providers and would coordinate presenters and workshop leaders for parent education sessions. The staff member also would conduct a needs assessment to determine which topics would be needed or desired by parents.

While the project was still working out the details of its interagency agreement with the school district, a report was submitted indicating that informal parent education and training was ongoing through a number of mechanisms. Medical visits to the onsite clinic involved some form of health care education for parents, and nutritional education also was being provided at the clinic by the nutritionist. It also was reported that some parenting education was being provided to parents during visits by the home visitors. The project anticipated formal parent workshops and training sessions on a range of topics to begin the following month.

Formal parenting classes began approximately 5 months after the initial site visit. The project submitted a quarterly progress report which indicated that the parenting workshop series was off to an excellent start and that topics during the first 6-week session would address child development, health care, well-baby care, and safety issues and would include a parent-child workshop as well. Classes for English-speaking parents were held with at least 13 parents in attendance; 29 Spanish-speaking parents attended the workshop series as well, with classes run in Spanish to aid them in taking advantage of the training being offered. The report also indicated that adolescent parents were meeting as a group, and the project was developing a workshop series to provide parenting education relevant for teenage parents.

The project submitted further documentation demonstrating that an acceptable parent education program and curriculum had been established and was being offered in both Spanish and English to meet the needs of CCDP parents. The program provided workshop descriptions and attendance sheets demonstrating that both mothers and fathers were involved in a variety of parent education workshops on topics such as health issues; infant and toddler safety; smoking, drugs, and alcohol; nutrition for the first 2 years, breast-feeding; first foods; stages of child development; toilet training; discipline; and cultural issues.

Case Management

Focus group sessions and individual discussions with case managers during site visits suggested that staff members were not sufficiently knowledgeable about their role as case managers. These sessions indicated that case managers often were uncertain about the array of services that CCDP was committed to provide and about the parameters of the case managers' role. Some case managers were confused about which members of the program family were to be recipients of services. When case managers were aware of the range of

services to be provided by the program, many were uncertain as to who had the responsibility to defray the expense for these services. Specifically, there appeared to be some misunderstanding about the responsibility of paying for child care, transportation, and routine (or acute) health care for adults. This lack of certainty about CCDP requirements was found to exist in 8 of the 12 programs, despite case manager reports of extensive training sessions provided by the projects. By the end of the startup year, case managers at all of these projects had demonstrated that they were knowledgeable of the CCDP requirements.

The remaining deficiencies noted in the category of case management possibly may be attributed to insufficient staff training. One of the most common issues was case managers' inability to access services in the community (6 projects). By the end of the startup period, the case managers at all of these projects had demonstrated their ability to access services for CCDP families.

Projects addressed these issues by educating staff members and providing specific training in the areas of deficiency. For example, at one project the findings of the site visit indicated that not all case managers knew what services were available and that some case managers were not consistently able to access these services. In response to this problem, the assistant director of the project was given primary responsibility for supervising the case management component and coordinating the case managers. In addition, the project established a coordinator for each core service area. The core service coordinators are responsible for (1) developing and maintaining referral networks and resources, including interagency agreements, with agencies in their core service area; (2) assisting case managers in solving problems and accessing resources in the coordinator's respective area; and (3) providing appropriate training to case managers in the coordinator's service area. The core service coordinators also provide each case manager with a written listing of resources in their service area.

Upon revisiting the project, site visit staff found that all case managers that participated in the focus group could identify all core services and that a service "menu" had been developed and distributed to each case manager. The service menu delineated each core service, the coordinating agencies that provide that service, and contact persons at and telephone numbers of the coordinating agencies.

Project Administration

Although almost all of the projects demonstrated that they had convened an advisory board to provide guidance and/or support to the project, several projects did not have sufficient diversity among the board's members. Specifically, projects had not uniformly sought the participation of representatives of the business community, who are ideally positioned to provide information on the employment opportunities existing within the community. The data obtained from the site visits indicate that eight of the projects lacked representation from the business community. Also, six projects did not include parents on their boards as mandated by the Federal Register announcement. By the end of the startup

year, all of these projects had adequate business and parent representation on their advisory boards.

One project, whose advisory board lacked adequate representation from both the business community and CCDP client families, addressed this issue in steps. Within 1 month of the site visit, the project had established a plan and timelines for achieving adequate representation of both groups on the advisory board. The plan stated that parent councils would meet at each site in 1 month. Each council would then elect two parent representatives to the advisory board within another month. In the month following their election, the parent representatives would receive orientation to the board by designated CCDP staff members. The parents then would be ready to attend the next board meeting, which would occur within the following month (approximately 4 months after the site visit). The project also secured the assistance of the local Private Industry Council in finding appropriate business sector representatives to begin serving on the advisory council at that same meeting.

Subsequent quarterly progress reports documented the election of parent representatives and their welcome and introduction during their first board meeting. At this meeting, the parents discussed needs in their respective neighborhoods, and board members offered suggestions to fill the gaps described. The ethnographer confirmed that parents received orientation to the board and found that parent representatives from one site understood that their role was "to take the concerns and ideas of the service families and the community to the advisory board...it was also emphasized that this must be a collective, group process—i.e., the parents are to represent the interests of the whole parents council and of the service families in general, not just their individual perspectives" (Ethnographer Report, Site N, February 1991).

At another site it was found that the advisory board lacked representation from the business community and that the board was not very participatory in nature, i.e., the board was meeting irregularly and was not given sufficient opportunities to provide input into project operations. Within 1 month of the site visit, the project was pursuing the representation of five large local employers—including the power and light company and a bank—for membership on the advisory board. Subsequent communication with the project revealed that adequate business representation had been added.

At the next meeting of the board, the purpose of the project and mission of the advisory board were discussed, and the board agreed to hold regular meetings. In addition, the board was organized into four working committees in the areas of (1) child care/early intervention/child development; (2) vocational training and education, parenting education, and job placement; (3) nutrition, health, and substance abuse; and (4) transportation and housing. Each of the committees was assigned a CCDP staff point of contact, and each agreed to hold meetings at least monthly. A subsequent visit to the project found that these committees were actively tackling issues such as how to ensure that core services are available and accessible to program families and how to continue these services after the period of Federal funding ends.

Summary

In conclusion, site visits to 12 projects revealed that in just over 1 year, the projects had become operational. Families were recruited and enrolled and were being served by CCDP. Most of the projects appeared to have built a strong foundation for future development by hiring well-qualified staff members, establishing their reputation in the community, reaching out to recruit families in varied ways, developing advisory boards, and working with other agencies. Many of the projects, however, were still in the startup phase. Numerous difficulties were encountered due to the demands of implementing many services at once and attempting to serve the neediest of families, many of which were continually in crisis. At many projects, these difficulties were manifested in the inconsistency of service delivery.

For most projects, many of the core services had been implemented, but the full array of required services were not in place at the time of the site visits. As discussed in this section, administration, parenting education, case management role and practice, child care, and early childhood education were areas in which most projects encountered their greatest challenges. Projects addressed these problematic startup issues in very different ways. However, almost all of the projects developed plans of action in which they identified difficulties and moved ahead with strategies and solutions. These plans of action resolved barriers to ensure that all CCDP families could be provided with the array of comprehensive services to assist them as they worked toward self-sufficiency.

CHAPTER 4: FACILITATORS OF PROGRAM STARTUP

CCDP is an innovative effort that incorporates state-of-the-art human service delivery concepts into a pragmatic program to promote child development and enhance family self-sufficiency. However, its innovative nature, comprehensive service delivery system and research requirements have made it a complex and, at times, difficult program to implement. The first year of CCDP operation was a full one for grantees. Major startup tasks were accomplished in most projects, and they moved into full program implementation. The tasks of family recruitment, hiring, training, and organization of services were more formidable than anticipated, and many projects experienced difficulties. However, by the end of the year, projects were into full program implementation, with only a minority of projects exhibiting major noncompliance with grant requirements. Most core services were in place, although problems with obtaining child care and providing developmentally appropriate early childhood education services in families' homes remained significant problems.

The complexity and difficulty of establishing a new multiservice program with few precedents at the Federal or local levels was probably underestimated by all involved. In examining the projects that performed best in accomplishing the startup tasks, a number of characteristics appeared that distinguished these projects from the projects that had more problems. This section discusses the site visitors' and Federal Project Officer's assessments of the factors that contributed to the facilitation of program implementation. Future reports will examine these issues in more detail using case study analysis.

Strong Management

Strong management was a good indicator of a successful startup. Strong project managers had a clear sense of direction for their projects and established programmatic goals early. These individuals managed people and funds well and generally had few problems with staff discord. They understood what skills their staffs would need and were successful in hiring people with these skills. Strong managers were able to juggle the implementation of many services, recruitment, hiring, training, securing space and licensing—essentially all of the administrative and managerial aspects of the program. Although all of the strong managers had relevant professional expertise, that expertise did not appear as critical as management skills. Indeed, in projects with weaker management teams, many of the members of the team had excellent professional credentials but were unable to cope as well with the multiple demands of the project and would frequently become overwhelmed or embroiled in one aspect (such as staff relationships, space procurement, or family crises) and unable to manage the overall effort.

Supervision

Projects that were best able to implement their programs had clear lines of staff supervision. These projects had developed job descriptions that defined each staff member's responsibilities and a supervisory system to ensure that tasks were being completed. Projects in which lines of supervision were less clear were ones in which the director and top

coordinators were "doing everything," delegating little, and being overwhelmed by the myriad of tasks. In some sites, projects had not anticipated the need for mid-level managers to coordinate direct service staff. When this need was recognized, projects often reorganized to fulfill this need. In some cases consultants were hired to promote team building.

Staff to Cover Critical Positions

Closely related to supervision was the presence of qualified staff members to cover key positions. If well-qualified staff members were employed, program startup was fairly smooth. In sites in which positions remained vacant for long periods of time or staff members were hired but were not qualified or did not agree with some of the basic premises of the project, more difficulties occurred.

In some cases staff did not have the practical relevant experience or they had ideological conflicts with the program philosophy. For example, in one project some staff felt "empowering families" meant providing no direction to move them toward self-sufficiency. This stance conflicted with the overall program goals and had to be resolved before progress could be made.

Staggered Start-Up

Projects that phased in their program operations and startup tasks were more successful than those that tried to start all or too many tasks at once. For example, projects that hired staff and recruited families immediately after grant award had more difficulties than those that hired staff, provided training, and developed and refined work procedures before recruiting families.

Relationship with Grantee Agency

In many sites, the CCDP project doubled the size of the grantee agency's budget and concomitantly increased its payroll, need for facilities, and management requirements. This new effort sometimes gave rise to jealousy, grantee agency directors' efforts to control the new program and thus undermine the authority of the project director, and competition for resources. In some cases project directors felt torn between programmatic demands from the Federal Government and those imposed by their grantee agencies. In some cases, despite the size of the grant, the grantee agency paid little attention to the project and its needs, continuing to focus on its previous programs. However, in the projects that were most easily implemented, relationships with the grantee agency were positive and supportive. In some cases this was due to a supportive agency that allowed much autonomy, in other cases it was the result of hard work by the project director to develop a positive relationship through recognition of the needs and interests of the parent agency.

Community Reputation

In communities in which the grantee agency had a good reputation among its client population or had previous experience in conducting community outreach activities with low-income families and cooperating agencies and either had a positive history of working with other agencies or made a concerted effort to establish positive initial relationships with them, startup was smoother. In particular, recruitment of families was facilitated because agencies were willing to refer families and to allow CCDP to recruit in their agencies. Also, families were trusting of the agency and willing to participate because of the agency's reputation.

Community Resources

Ready access to community and public agency resources that were available and adequate to meet family needs was a facilitator of implementation. Because of the relationships developed by the project, families were able to secure the goods and services they needed. These positive relationships aided the reception of both core services, such as health care, as well as additional services, such as food, clothing, and legal assistance. The availability of these services enabled projects to begin operation sooner as many of the key components for a comprehensive program were already in place.

Smaller Number of Families

The smaller projects seemed to have an easier startup than did the larger ones. The sheer size of the task of recruiting and serving 120 (or more) low-income families with their many needs made program implementation difficult. This finding is confounded somewhat by the fact that the larger projects are in urban areas, which have more severe problems. Generally, however, the smaller programs were the first to be "up and running."

Community Context

The environmental context of the project greatly affected its ease of implementation. Projects located in mid-sized or small towns had an easier startup process than those in inner cities, with their concomitant problems of drugs, crime, unemployment, and lack of housing. Projects serving inner-city families had to address more severe and continual family crises; had more difficulty obtaining space, licensing, and services; and had more staffing problems—both the difficulty of hiring people to work in dangerous neighborhoods and internal staff problems—than other sites. The inner-city location compounds all the problems other projects face and requires even greater managerial and agency strength in order to succeed.

Some rural sites also faced difficulties, however, due to the unavailability of services and the long distances that staff had to travel and/or the unavailability of public transportation for families that inhibited their use of services.

All projects faced the challenge of developing a multifaceted program in a fairly short time period. Coupled with the requirements for the experimental design, the MIS, and the statutory mandates, the projects' task was a difficult one. As the projects continue to mature, some of these factors may change in importance, but for the first year the above factors clearly facilitated program implementation.

The coming year should reveal the extent to which projects and services reach a point of stability. Also, positive effects, especially on parental accomplishments in education, job training, and employment will be able to be monitored and assessed.

CHAPTER 5: EARLY FAMILY SUCCESSES

Although the impact evaluation has not yet begun to provide empirical evidence of the effects of the program, families have given staff members, ethnographers, site visitors, and Government officials many examples of the positive effects CCDP is having on families' lives. Effects have been seen in attitude changes about life from despair to hope, in feelings of self-esteem in parents, in concrete accomplishments on the road to self-sufficiency, and in child growth and development.

Comments in focus groups during site visits, interviews with ethnographers, and letters and newsletter reports from projects have revealed these effects.

Families say that the program gives them hope:

"I gave up until they helped me." (Site N)

"Getting help from [CCDP] is good—instead of someone saying 'Girl, you can't make it.'" (Site C)

CCDP gives families help.

"[CCDP] is a support to a person trying to get ahead and make a better life for her children." (Site C)

"CCDP is someplace to turn for help. It will make a difference in lives. It will make a difference in how a child grows up—whether he will become an Al Capone or a George Bush." (Site G)

Families value the services their children receive.

"[CCDP] involved my 3-year-old in preschool, and I am thrilled with it! He has picked up so much just from being with the other kids." (Site A)

A teen mother reported, *"[CCDP] paid for seat belts and a baby seat so we could go to school." (Site E)*

"CCDP helps you get to participate in group discussions on how to deal with children without abusing them." (Site N)

"I appreciated the [developmental] testing. It showed low areas, and I was able to assist my kids. CCDP gave me ways to work in their weak areas." (Site A)

The case management services provide direction, assistance, and support.

"If you need someone to talk to, there is a family advocate...to talk to." (Site Q)

"The counselors really get involved with the participants and help with many legal and personal problems." (Site F)

"My case manager assists with finding resources when I can't find them. [She] acts as an advocate for me with other agencies." (Site A)

The program promotes goals for employment and economic self-sufficiency.

To a site visitor, *"Next time you come back, I'll be a computer specialist!"* (Site N)

"My main goal is to get an education and get off welfare, so my kids don't have to be on it." (Site A)

"Now that I have my three kids in day care, I can get a job." (Site B)

"I came to further my education; I need more than a GED." (Site C)

"CCDP helps you to benefit yourself, provides services, and gives you a chance to go to school." (Site N)

Even in the first year, some family members had returned to high school or enrolled in GED programs, training programs, or college.

In December of 1990 the newsletter of Site A, which serves 60 families, reported that 4 parents were enrolled in and 2 had completed training programs; 4 were working toward their high school diplomas; 3 had enrolled in college, including a father who made the dean's list; 3 had obtained jobs; and 1 had been licensed as a group day care provider.

In Site H, a mother's letter reported, "I am currently attending community college, working toward my associate's degree. The [CCDP] provides us with transportation, child care and an excellent support group.... I am very happy to be able to participate in a program that helps me go to college and better myself."

In Site F, another mother wrote, "The [CCDP project] helped me get into a drug treatment program [from which] I am a graduate. I am also in the JOBS program, trying to get my GED, and my daughter is in day care...they help give me motivation to do something with my children and my life. And that's a big PLUS. I love this program so much because the people there care."

Finally, in Site G, a young single mother with two children wrote, "I wanted to graduate from high school, but I couldn't because I had to raise my children. I was attending [the CCDP] family meeting when my family advocates suggested I attend a GED program. I am going to get my GED, and someday I may even be a writer." She ended her letter with a poem which concluded:

"This business of living was never meant
As a treadmill kind of thing
There are rivers to cross and mountains to climb
And glorious songs to sing."

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APPENDIX I
MANAGEMENT SUPPORT ACTIVITIES AND PRODUCTS

This section of the report details the activities performed and research conducted in support of Contract Number 105-89-1623, *Management Support for the Comprehensive Child Development Program* for the Administration for Children, Youth and Families (ACYF) of the U.S. Department of Health and Human Services between October 1, 1989 and December 31, 1990. During this first year, a sophisticated and comprehensive automated management information system (MIS) and unit cost analysis system were developed; random assignment techniques were developed; family eligibility criteria were established; a case analysis approach and framework were formalized; a process evaluation design was drafted; an electronic bulletin board was developed; three conferences were convened; twelve intensive site visits were conducted up to December 21, 1990; and extensive technical and managerial support was provided to the projects and FPO.

Development and Testing of a Management Information System

P.L. 100-297, which created the Comprehensive Child Development Program (CCDP), requires grantees to collect data on "groups of individuals and geographic areas serviced, including the types of services to be furnished, estimated costs of providing comprehensive services on an average per user basis, types and nature of conditions and needs identified and met, and such other information that the Secretary may require." The need for these data was stated in the December 29, 1988 *Federal Register* announcement. The supplement to this announcement, included with the grant application packet, stated that grantees would be required to use a management information system (MIS). The MIS would record data "on families, programs collaborative arrangements, on-going services and costs." The supplement also stated, "Grantees will be responsible for collecting information on all data elements required by the MIS using data entry forms developed by the contractor. . . .Grantees must cooperate with the management support contractor in this effort." Grantees were required to hire a full-time data manager who would be responsible for coordinating this data collection effort. All CCDP grantees budgeted for this position in their final proposals, and the need for and importance of this position was reiterated to each grantee during final negotiations prior to grant award.

One of the critical objectives during the first year of the CCDP management support contract was to design, develop and implement a management information system to support the data collection requirements specified in the law as well as provide a management tool for the individual projects. As is often the case with management information systems, this assignment involved activities associated with many Year One Project Tasks, including:

- Developing data elements, data definitions and forms to record the enrollment of and service delivery to program, comparison and replacement family members;

- Conducting field tests of the MIS forms, and incorporating appropriate revisions into the system;
- Preparing the OMB clearance package;
- Developing the processing software and operating procedures for the data collection forms;
- Training users of the system through presentations at conferences, through telephone assistance, electronic bulletin board, and on-site technical support; and
- Implementing the CCDP MIS software and documentation at each site.

Forms Development Process

During the first month of the support contract, basic topic areas and data elements to be included in the MIS were identified. In developing these topics, the authors considered the services CCDP grantees were to provide, the evaluation needs of the project and the information that would routinely be recorded by a service provider to manage the program effectively (such as a needs assessment, service plan and contact with the family).

The topic areas and data elements were presented to grantees during the first CCDP conference held in early November 1989, about one month after CCDP grant award. At the conference, CSR and its subcontractor, Information Technology International (ITI), presented plans for the MIS to grantee project managers, data managers and service provider staff in small group sessions. Data topics and elements were reviewed by the group, and the grantees made suggestions for items to add and eliminate.

Using this input, a draft set of MIS forms and instructions was developed in early December 1989. These were mailed to each grantee and to a panel of outside consultants identified by ACYF. The grantees and consultants provided comments by mail, and the forms were revised extensively in December and January to accommodate their concerns and suggestions. The revised forms were presented to grantees a third time in May, 1990, during the second CCDP grantees' conference. The purpose of each form and its proper completion were reviewed with small groups at the conference. Further comments on form content, including the feasibility of obtaining the information, burden involved in its completion and information on what would be useful to grantees for their own purposes also were solicited at that time. Additional changes to the forms were made based on these comments.

Field Test of MIS Forms and Procedures

Field testing of the data collection forms to be used in the MIS was conducted in May and June 1990. Four grantees, Washington, DC; Brooklyn, New York; Logan, Utah; and Little Rock, Arkansas volunteered to participate in the field test. The major purposes of the field tests were to:

- confirm the validity of data element definitions;
- assess grantee preparedness to collect and input data; and
- review staff procedures for adequate, on-going data collection and reporting.

For each of the field tests, the grantee received a complete set of CCDP MIS data collection forms and instructions several weeks prior to their two-day site visit. The grantee was requested to review this information carefully, determine what procedures would be implemented within their program to collect the information requested on each form and to complete a sample of forms. This process involved both the grantee staff members responsible for service delivery, and, when appropriate, other program participants such as local agency staff.

Each of the four field tests produced similar results. In brief, at each site there was some initial misunderstanding of specific forms and data elements; when these areas were clarified during the field test, the purpose and procedures associated with the forms were strongly endorsed.

A secondary benefit of the field test was an improvement in the precision and utility of the forms and data definitions. Instructions were again revised and data codes expanded or modified based on suggestions from the grantees and comments from the second CCDP conference. In total, these changes resulted in minor technical modifications to the data elements and forms, but fairly extensive changes to the instructions.

Development and Revision of OMB Package

The Administration for Children, Youth and Families must secure U.S. Office of Management and Budget (OMB) approval of the MIS under the Paperwork Reduction Act and CFR 1320. The OMB review is intended to ensure that the data to be collected are needed, do not pose unnecessary respondent burden, and yield meaningful information that address specific management questions.

Work began on the OMB package in March, 1990. After several reviews, approval was received on April 29, 1991.

Software Development

The CCDP MIS is a comprehensive, integrated system for organizing and manipulating required data. The system operates on personal computers, using a relational data base. The system provides project staff with the ability to add, edit and report all **Family, Health, Education, and Administrative** information required by Congress and by ACYF to administer CCDP activities. The scope of the CCDP MIS may be demonstrated through the following statistics:

- Twenty data collection forms;
- One hundred computer programs;

- One hundred-ten data base files;
- Thirty-five reports and thirty reference files; and
- Approximately 1,500 data elements.

The CCDP MIS satisfies the requirements of the ACYF Program Office and will provide considerable information to the program evaluation effort.

Users Training

Following the third revision of the forms and instructions and the completion of the MIS software, a training conference was held for project directors and data managers in August, 1990. All forms and procedures were discussed in detail during this two-day conference, and data managers were provided hands-on experience in using the MIS on personal computers. Group discussions were held with all data managers on ways to collect MIS information, and procedures were suggested for developing an effective data collection system. In addition, three data managers gave presentations on methods they were developing for collecting data and using the MIS in ways that minimized burden.

Trainers emphasized that grantees should examine the data collection already taking place in their programs to determine how that information might be used to satisfy the data requirements of the MIS. For example, some grantees routinely collect attendance information on children in their early childhood education programs (e.g., Head Start grantees). These attendance records could be turned over to the data manager in lieu of the forms developed for the CCDP project. Grantees also were informed that they could use their own methods for collecting the information required by the MIS. Several grantees planned to do this instead of using some of the forms. For example, at least two grantees will have their case managers use log books to record their contacts with families instead of using the CCDP Family Contact Summary. Grantees were encouraged to use whatever methods work best for their individual projects and not to be constrained by the forms.

Bulletin Board

In parallel with the development of the MIS, the CCDP Electronic Bulletin Board (BB) was developed. The BB is an online computer network of the 24 CCDP project grantees, used by the management and technical support contractors, and the Federal Project Officer (FPO). The BB allows the projects to communicate with CSR, ITI, and each other via electronic mail. Users can access help and message screens which are used to identify resources, and distribute directives and up-to-date information about CCDP conferences, site visits, and the MIS. Computer files also can be obtained through a "download" procedure via modem. The latter use allows recruitment data to be submitted in minutes and checked within 48 hours, expediting enrollment considerably when compared to the time required when mailing paper forms or even floppy disks. Users also can "leave mail" for each other on the BB message center, which helps the projects feel less isolated as they query other grantees on solutions for various problems or exchange messages.

The BB operates out of CSR's offices in Washington, D.C. The same computer hardware used for the MIS and purchased by all grantees can be used for accessing the BB. Because CCDP data managers are the primary operators of the MIS hardware and software, they also are the principal users of the BB. At the first CCDP conference the data managers chose log-on names (i.e., chose how they would be identified within the system—e.g., **FULL CIRCLE, ITI**, or the user's first and last names) and passwords. Passwords are a standard feature of most online networks because they allow the system to remain "closed" to outside users and keep private mail secure. In addition to data managers, some project directors and ethnographers chose their own log-on names and passwords so they could access the system independently.

There currently are 39 registered users from all of the 24 project sites. Each of the grantees have accessed the BB at least once, with most logging on at least once per week. The BB has been a popular service of the CCDP, and it has allowed not only communication between the grantees, CSR, and ITI, but it also has promoted networking among the data managers.

Convening of Conferences

During the first 15 months of the contract, four major CCDP conferences were convened for staff from the 24 projects. The main goals of these conferences have been to provide the grantees the opportunity to network and meet with the Project Officer as well as with the management support contract staff, and to receive training in areas related to programmatic concerns at each stage in the implementation of their projects. To achieve these goals, the conferences were organized to include both general sessions in which all conference participants were present and break-out sessions, in which participants met in smaller groups organized around topics relevant to their position(s). See Attachment 2A for a sample agenda. The following provides a summary description of each conference.

First CCDP Conference

Date:	November 7-10, 1989
Objectives:	• To provide an opportunity for grantees to meet each other and build a team spirit • To review federal guidelines for CCDP • To begin development of MIS process and obtain feedback from grantees • To receive programmatic training and information
Attendance:	90 participants
Location:	Omni Georgetown Hotel, Washington, DC
Content and Speakers:	See Attachment 1A.

Second CCDP Conference

Date:	May 8-11, 1990
Objectives:	• To provide training in the use of the MIS to data managers • To provide information on guidelines for first ethnographers' report and training on the use of the guidelines • To provide opportunities for grantees to network • To provide training on Family Support Programs; facilitating linkages with provider agencies; screening and assessment of infants, toddlers and youth children; drug/substance abuse identification and treatment; and in other relevant issues related to interventions with culturally diverse families with young children.
Attendance:	149 participants
Location:	Holiday Inn Crowne Plaza at National Airport, Crystal City, VA
Content and Speakers:	See Attachment 2A.

Third CCDP Conference

Date:	August 20-21, 1990
Objectives:	• To provide training in the use of the MIS software • To provide the opportunities for grantees to network • To provide training on different areas of service delivery • To provide training to ethnographers on the development of the first ethnographer's report • To provide project directors the opportunity to meet with the Project Officer • To provide grantees the opportunity to present different components of their programs to their colleagues
Location:	• Loew's Hotel Annapolis, MD
Attendance:	72 participants
Content and Speakers:	See Attachment 3A.

Fourth CCDP Conference

Date:	November 5-8, 1990
Objectives:	• To provide the opportunity to data managers to share their concerns about data entry • To provide the opportunity for grantees to network • To provide training on different areas of service delivery • To provide project directors to the opportunity to meet with the Project Officer • To give a description of the process for the impact evaluation
Attendance:	139 participants
Location:	Omni Shoreham Hotel, Washington, DC
Content and Speakers:	See Attachment 4A.

Programmatic Site Visits

ACYF with assistance from CSR/ITI conducts an annual programmatic site visit to each project. The purposes of these site reviews are:

- to ensure CCDP grantees are in programmatic compliance with their proposals and with the guidelines described in the *Federal Register*, Comprehensive Child Development Act and other ACYF programmatic guides;
- to review the grantee's service delivery and data collections systems;
- to identify grantees' concerns and technical assistance needs;
- to provide technical assistance when needed; and
- to obtain qualitative data on program quality to complement the quantitative process evaluation information.

To reach these goals, a planning and implementation procedure for the site visits was developed. The sequence established follows.

Site Visit

- Initial orientation
- Staff interviews
- Observation of program components
- Parent focus groups

- Case manager focus groups
- Advisory Board meeting
- Interviews with community agency staff
- Debriefing with senior staff

Documentation

- Letter detailing *Strengths, Non-Compliance Issues, Areas Needing Improvement, and Suggested Action Plan*

- Site visit report

For the collection of information, a set of discussion guides designed for interviews with key program staff, observation guides for different activities, and discussion topics for parent and staff focus groups have been developed and are modified according to site specific organization and needs.

Site Visit

Observation/Interviews

Upon arrival at the site, an initial orientation meeting is conducted during which the visit agenda is confirmed. As the visit proceeds the team spends extensive time with the various components of the CCDP staff and coordinating organizations from which the CCDP project receives supportive services. In addition, the team hosts a parent focus meeting with six to eight participating project families. The purpose of this meeting is to generate discussion about experiences with the project and the services they have received. The team attends the CCDP project's advisory board meeting which provides an opportunity to interact with the board and observe its functioning. A focus group is held with case managers. The team members accompany the home visitors to observe the nature of activities being implemented in the homes. Team members also observe child care facilities in which both focus children and their siblings receive care, to ensure that the facilities meet Head Start Performance Standards. Parenting classes and parent/child interaction activities are also observed. Operation of the MIS and its procedures are observed and discussed with the data managers. Administrative and programmatic records are also reviewed.

Debriefing

Upon completion of the visit, the team provides a verbal debriefing to the senior project staff personnel and the ethnographer. This debriefing provides feedback on the observations made during the visit, identifying areas of strength and programmatic issues existing at the site in the areas of administration; case management; health; early childhood/early intervention; child care; adult education/employment and parenting training; and in the implementation of the management information system.

Documentation

Post Site Visit Letter

One week after the visit, a post site visit letter providing information on the site visit observations and a suggested course of action is sent to the CCDP from the FPO. This letter lists the CCDP project's strengths and program issues in the areas of administrative, early childhood education/intervention, case management, health and parent education and training.

Site Visit Report

One month after the first year site visit, a site visit case study report is written that details the information to date on that CCDP project site. This report describes background information on the site. It addresses the development and start-up of the project and describes the sponsoring agency commitment; planning strategies used; the history of the family recruitment process; the hiring of personnel; the location of facilities; the service implementation status; the coordination/management structure; current linkages with agencies; and the delivery of core services, including health services, early childhood education and early intervention, case management, and adult education, training and job placement services. Non-core services and budget information are also addressed.

Finally, the report includes a description of the management information system setup and operation. This part of the report documents hardware, software, communications, backup and recovery, access and security, ID assignment, data collection procedures, and specific data collection by staff personnel.

Guidelines for Eligibility, Family Definition

Eligibility

Because CCDP is a demonstration project it was designed as an experiment to test the impact of the services on children and parents. Projects were required to select three times their target service population and randomly assign them to treatment (program), control (comparison), and replacement groups. Because the evaluation contractor had not been selected at the time projects began recruiting, CSR and the FPO developed the random assignment procedures and eligibility criteria to be used by the grantees.

The following guidelines were developed for the recruitment, sampling, selection and replacement of families.

CCDP Eligibility

To be eligible for enrollment in the CCDP, a family had, at the time of enrollment, to:

- Have income[1] below the 1989 Federal Poverty guidelines;[2]
  and
- Have an unborn child or a child under one year of age (focus child);
  and
- Agree to participate in CCDP activities for 5 years.

CCDP Family Definition

A **CCDP family** is comprised of two or more people related biologically or by marriage, adoption or commitment, who reside in the same household. A **CCDP family member** includes any children of the primary family caregiver under age 18 in the household and any other family members residing in the household who have major responsibility for the nurturance of the focus child (except that the focus child's biological or adoptive parents who reside outside the household may be included). CCDP family members must receive all core services required by *Federal Register Announcement* #13600-883 published December 29, 1988, and enumerated in the Programmatic Requirements section of the grant award document. Other household members not included in the above definition may receive selected CCDP services at the discretion of the grantee on an as-needed basis.

Family eligibility can change over time. Examples of some possible changes and their effects on eligibility are given below.

a. If a family was participating in the CCDP, and the family income rises above the poverty line at any time over the five project years, the family may remain in the project.

b. If, over the course of the project, the focus child ceases to reside permanently with the CCDP family, either through moving or death, the family remains eligible to receive CCDP services for 12 additional months.

c. If the focus child moves to a new permanent household in the same service area, the new family will become eligible for the CCDP if they are *income eligible*. If

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1 Income from all CCDP family members had to be included in the calculation of family income eligibility.

2 1989 income guidelines and eligible sources of income appear in ACYF Information Memorandum ACYF-IM 89-13. Income eligibility for enrollment in subsequent years will be based upon the published income guidelines for those years.

they are not income eligible, the child may continue to receive CCDP services for 12 months.

Some examples of CCDP eligible family compositions were presented as follows:

Examples

Eligible for CCDP Core Services

a. A married couple in which the mother is pregnant and/or has a child under one year and other children.

b. A single pregnant woman.

c. A single parent and her/his child under a year and other children.

d. Parents of a, b, or c families (grandparents) if parents reside in the same household and provide major nurturance to the focus child.

e. Partner of b or c families if partner resides in the same household.

f. The non-resident parent of the focus child.

Not Eligible for any CCDP Services

a. Relatives of an eligible mother who do not reside with her.

b. Children of participating mother who do not reside with her (except foster care children where goal is to return home).

Eligible for Selected CCDP Services

Other household members who do not provide major nurturance to the focus child of an eligible parent, e.g., adult siblings of the eligible mother who live with her.

Exceptions were evaluated on a case-by-case basis by the FPO.

Recruitment

Grantees followed these guidelines for recruiting families.

1. The community needs assessment, U.S. Census data, state or county surveys and/or other appropriate sources can be consulted for recruitment area population characteristics.

2. The recruitment area has to be within the service area.

3. Recruited families are to be proportionately representative of the poverty population of the grantee's recruitment area in terms of *two strata: ethnicity* and *age of primary caretaker* (teenage or not). For example, if 20 percent of eligible families in the recruitment area are headed by a teenage parent, the project has to serve approximately this proportion of such families. In addition, recruited families have to represent a range of income levels below the poverty line. The grantees had to submit community data on these characteristics, (if available) to CSR.

4. Grantees can serve other income-eligible specific target groups as well. For example, families with substance abuse problems, handicapped children, HIV positive mother and infants, or other special need groups may be specifically targeted. However, the percentage of such families served by the program has to reflect the proportionate distribution of these families in the project's recruitment area.

5. Initially, grantees have to recruit a pool of eligible families from their recruitment areas equal to at least three times the number of families to be served by the program. For example, if the program is to serve *120* families, *360* families have to be recruited—120 to serve as **program families**, *120* to serve as **comparison families** and *120* to serve as **replacement families**.

   a. The grantee has to identify the number of families needed in each of the *two strata* to conform to the recruitment requirements prior to commencing recruitment. For example, Exhibit 1 demonstrates the number of families to be recruited in each strata for a project that would be serving 120 **program families**.

Exhibit 1

Sample Target Recruitment Requirements
To Serve 120 Program Families

Recruitment Area Characteristics

	Ethnicity			Age of Primary Caregiver	
	White	**Black**	**Hispanic**	**Teenager**	**Not Teenager**
Percentage in Recruitment Area	35%	40%	25%	25%	75%
Number to Recruit	126	144	90	90	270
TOTAL		360		360	

b. The number of required families can vary from this number due to different rates of acceptance and other recruiting difficulties. The program were to try to reach these recruiting targets and provide an explanation in writing if they could not. The program submitted the completed MIS recruitment forms (provided with the MIS package) for each recruited family to CSR within two weeks after each recruiting cycle so that progress toward these goals could be monitored.

6. Once a family has been recruited and determined to be eligible, the program is explained to the family and a letter of commitment to participate is signed. The family is informed that they have been assigned to the **program, comparison** or **replacement** group and has committed to stay with the project for five years. For those grantees whose grant proposals depict families being assigned to groups from existing eligibility lists before they were recruited, the letter of commitment was revised to refer only to the group to which the family is assigned.

Random Assignment

Grantees followed these steps to assign recruited families to the program and comparison and replacement groups:

1. A list of all recruited families is placed *in alphabetical order.*

2. Families are randomly selected to be in the **program, comparison** and **replacement** groups from the alphabetized list using a *random number start* and *sampling interval* provided by CSR. (The grantee either had to be able to demonstrate the sampling method used or could provide the list of recruited families to CSR staff to draw the sample. The grantee could use another procedure for random assignment upon written approval from the FPO.) Random assignment is conducted after each recruiting cycle.

3. All three groups of families are notified of their assignment. **Program families** then are enrolled in the program. Additional information on comparison families is completed using the family profile form provided with the MIS package.

4. **Comparison families** receive a $100 stipend annually but are not to receive any CCDP project services. **Comparison families** are not to be used as **replacement families**. (Grantees could provide a resource directory or similar compensatory materials to the **comparison** and **replacement groups** but were then to have no further involvement with **comparison families** except for administrative purposes, such as to maintain contact, mail stipends or arrange testing for the evaluation contract.) **Comparison** and **replacement families** may receive other services available in the community.

5. After the sample worksheets and MIS recruitment forms are submitted to CSR, statistical tests are conducted to determine whether statistically significant differences exist between the **program** and **comparison groups**. If differences are found, alternative assignment procedures are recommended.

Replacement of Families

Grantees followed these steps in replacing families.

1. All families who drop out of either the **program** or **comparison groups** for any reason are to be replaced with a **replacement family**.

2. During the first project year, grantees maintain a list of **replacement families** from their initial recruitment procedures. Families on the replacement list who are selected to enter the program or comparison group must still meet the CCDP eligibility criteria in order to be enrolled.

3. **Replacement families** must be randomly selected to replace families as needed, unless there is a statistically significant imbalance among any demographic group in the grantee's enrollment sample.

    a. If an imbalance exists, families with the needed characteristics are identified and randomly assigned to the appropriate group as needed. For example, if the number of teenage-parent families in the **program group** becomes too low, all teenage parent families among **replacement families** are identified and randomly assigned to the **program group** as families drop out, until the required number of such families is obtained.

4. As replacement pools become depleted, grantees must recruit *a new group of **replacement families***. These families are recruited according to the criteria and procedures described earlier.

5. The number of **replacement families** to be recruited in subsequent recruiting cycles should be the estimated number of families that will drop out of both **program** and **comparison groups**. For example, if a program has 120 **program families** and 120 **comparison families**, and the overall drop-out rate is 50 percent, 120 **replacement families** should be selected. If drop-out rates are significantly higher by strata (e.g., teen parent families), additional families for the stratum should be recruited.

GROUP ASSIGNMENT PROCEDURE BY GRANTEE — JANUARY, 1991

Roxbury, MA

Assignment method: Followed CSR method.
Number of rounds: 1
Group composition: Assigned equally to three groups
Group sizes: 120/117/116

Brattleboro, VT

Assignment method: Followed CSR method.
Number of rounds: 4
Group composition: Assigned equally to three groups until round three (53/51/52); then assigned replacements to program and comparison until 60 in each; then recruited remaining replacements in round 4.
Group sizes: 54/51/60

Brooklyn, NY

Assignment method: CSR drew sample using alphabetical lists and sampling fraction of 3.
Number of rounds: 4 (not yet complete)
Group composition: Assigned all original replacement families to program and comparison and recruited a new set of replacements.
Group sizes: 71/71/72

District of Columbia

Assignment method: Followed CSR method but stratified by age and race and ward.
Number of rounds: 2 (replacements not complete)
Group composition: Assigned equally to three groups in first round (80/76/68); however, there was long lag after first recruitment to initial contact and about one-third of initial families could not be located. After second round, project began to assign replacement families to program and comparison group; in total, 203 could not be located after initial recruitment.
Group sizes: 120/120/106

Lexington, KY

Assignment method: Followed CSR method.
Number of rounds: 4 (replacements not complete)
Group composition: Assigned equally to three groups in first two rounds (44/43/42); in remaining rounds recruited only program and comparison.
Group sizes: 120/120/42

Baltimore, MD

Assignment method: Followed CSR method.
Number of rounds: 5 (replacements not complete)
Group composition: Assigned equally to three groups in first round (51/51/51/); in round two recruited only program and comparison and used replacements; in remaining rounds recruited only replacements.
Group sizes: 120/120/34

Nashville, TN

Assignment method: All families were randomly assigned into groups stratified for site, race, and teen status (according to demographics).
Number of rounds: 1
Group composition: Assigned equally to program, comparison, and replacement groups, however, families yet to be assigned remained in the replacement group.
Group sizes: 60/60/165

Grand Rapids, MI

Assignment method: Followed CSR method.
Number of rounds: 13
Group composition: Assigned equally to three groups in first eight rounds (77/70/73); in round nine recruited only program and comparison and used some replacement; in rounds 10 and 11 recruited only program and comparison until goals were reached; in rounds 12 and 13 recruited replacements only.
Group sizes: 120/120/34

Nashville, TN

Assignment method: All families were randomly assigned into groups stratified for site, race, and teen status (according to demographics).
Number of rounds: 1
Group composition: Assigned equally to program, comparison, and replacement groups, however, families yet to be assigned remained in the replacement group.
Group sizes: 120/120/120

Glenwood City, WI

Assignment method: All families were randomly assigned by a computer program, stratified by race and teen status (according to area demographics).
Number of rounds: 3 (replacements not complete)
Group composition: Assigned only to program and comparison in first two rounds. Round three recruited replacement and some program and comparison to make up for drop-outs.
Group sizes: 58/59/41

Albuquerque, NM

Assignment method: Followed CSR method.
Number of rounds: 2
Group composition: Assigned equally to all three groups.
Group sizes: 180/180/180

Little Rock, AR

Assignment method: Computer-generated random numbers assigned to families (approved by FPO).
Number of rounds: 13 (recruitment not complete)
Group composition: Assigned equally to program and comparison groups; replacements not yet recruited.
Group sizes: 107/101/0

Marshalltown, IA

Assignment method: CSR drew sample using list and sampling fraction.
Number of rounds: 2 (recruitment not complete)
Group composition: Assigned randomly to three groups separately for separate projects sites. However, program and comparison groups were formed with a predetermined equal N. Replacement group was smaller.
Group sizes: 99/99/33

Las Cruces, NM

Assignment method: Followed CSR method but families were randomized separately for each site.
Number of rounds: 1 (recruitment not complete in one site).
Group composition: Assigned equally to all three groups.
Group sizes: 60/60/60

San Antonio, TX

Assignment method: Followed CSR method.
Number of rounds: 2
Group composition: Assigned equally to all three groups.
Group sizes: 120/120/120

Fort Worth, TX

Assignment method: Followed CSR method.
Number of rounds: 1
Group composition: Assigned equally to all three groups.
Group sizes: 120/120/120

Kansas City, KS

Assignment method: Followed CSR method.
Number of rounds: 1
Group composition: Assigned evenly to all three groups.
Group sizes: 120/120/117

Denver, CO

Assignment method: First round of 55 families all assigned to program group without authorization and in violation of ACYF requirements; assigned randomly to program and comparison group thereafter.
Number of rounds: 3 (recruitment for replacements not complete)
Group composition: Program and comparison recruited first.
Group sizes: 120/120/26

Logan, UT

Assignment method: Followed CSR method stratified by age and race.
Number of rounds: 4
Group composition: Assigned equally to all three groups.
Group sizes: 60/60/60

Phoenix, AZ

Assignment method: CSR drew sample and assigned groups.
Number of rounds: 2 (replacement not complete)
Group composition: Assigned evenly to program and comparison first.
Group sizes: 120/120/0

Pittsburgh, PA

Assignment method: Followed CSR method.
Number of rounds: 7 (recruitment not complete)
Group composition: Assigned evenly to all three groups separately by site.
Group sizes: 41/39/39

Venice, CA

Assignment method: Used computer generated randomization program.
Number of rounds: 3 (replacement not complete)
Group composition: Assigned evenly to program and comparison.
Group sizes: 115/112/0

Auburn, WA

Assignment method: Used computer generated randomization program, assigned separately for each site.
Group composition: Assigned to program and comparison groups equally based on desired N; replacement group N determined by estimating attrition rate.
Group sizes: 125/123/82

Ethnographic Case Studies

To obtain a narrative description of qualitative contextual variables influencing feasibility, overall quality, and utilization of services in each of the CCDP projects, ACYF added an ethnographic research component that would supplement the quantitative information gathered by the MIS.

Each of the 24 CCDP sites hired a part-time ethnographer. Most of the ethnographers are trained case study researchers holding a doctorate degree in the social sciences.

Framework and Guidelines

The first task in implementing this new component involved the development of a framework and guidelines for use by the ethnographers. These documents were crucial in providing a standardized format and common structure so that the information contained in case studies conducted at 24 different sites could be compared and analyzed around common themes. The framework and guidelines (see Attachment 5A) were developed after intense discussions with the ethnographers at the May 1990 conference, and therefore, represent the ethnographers' input and ideas.

The framework is intended to provide an overall conceptual model for the ethnographer's efforts. It presents an ecological perspective focusing on four domains: the

community, the community service network, CCDP program/service delivery, and the family. Under each domain, relevant questions/issues pertaining to factors involved in program feasibility and family utilization are listed. It was not expected that any one of the ethnographer's reports would cover all of the questions listed in the framework. Rather, priority topics and selected questions from the framework were identified in the guidelines for each of the reports.

Three reports are required in the second year of CCDP; the due dates for these reports are: November 15, 1990, February 15, 1991, and June 15, 1991. Major topics in the first report included: Planning/Start-up Activities, Program Goals/Systems and Organization, and Contextual Issues (social, economic, and political issues of the community as they impact on CCDP). (See *Guidelines For the First Report,* Attachment 6A.) Major topics to be addressed in the second report include: Continued Planning/Startup Activities, Service Network, CCDP Service Model/System, and Family Response (See Attachment 6A).

In preparing these reports, the ethnographers may utilize a variety of sources of information, such as interviews with parents, CCDP staff or community agency staff; written documents; and observations of advisory board meetings or CCDP service provision. To ensure that the ethnographer's reports remain focused, a 25-30 page limit was imposed. In addition to the major topics in the guidelines, each report must include an introduction, summary, and methodology section.

Ethnographer Training

The majority of training for ethnographers took place at two sessions during the August 1990 conference which was attended by most of the CCDP ethnographers. The first session focused on a review of the draft framework and guidelines; the general reaction to these documents was positive. A variety of questions/issues needing clarification were discussed, such as the intended use of the ethnographer's reports; the relationship between the ethnographer, project director, and ACYF; and the possibility of ethnographers providing feedback and/or technical assistance to the projects.

The second session focused on the sharing of research techniques by the ethnographers themselves. Techniques discussed included: a structured town hall meeting, parent focus groups, attendance at picnics and other informal activities, wish-list questionnaire for newly enrolled parents, Eco Maps, diagramming the spatial positions of group members, and the use of alternative data sources and/or informants to obtain information on the community. In addition, several other issues regarding the collection of data were discussed such as the use of consent forms; access to program families; gender and race issues; the use of graduate students and assurance of quality control; attrition of ethnographers and the need for documenting activities; and publications.

Informed Consent Forms

Three *Informed Consent Forms* (in both English and Spanish) were developed and sent to grantees to be used when recruiting and enrolling families. These forms conform to the "Protection of Human Subjects Guidelines." The forms developed were:

- Informed Consent Statement for Program CCDP Family Member Adults (for themselves). Declaracíon de Consentimiento Informado Para Adultos Miembros de la Familia.

- Informed Consent Statement for Program CCDP Family Member Primary Caregiver (for themselves and their children). Declaracíon de Consentimiento Informado Para Miembro de la Familia que es Cuidador Primario.

- Informed Consent Statement for Comparison Primary Caregiver (for themselves and their children). Declaracíon de Consentimiento Para Cuidador Primero del grupo comparatiud.

Additional Programmatic Guidelines

During the first year of operation, many issues emerged that needed clarification. More specific guidelines on eligible families, core and non-core services, coordinating agencies, program and budgetary changes, program and fiscal reports, undocumented families, and recruitment were developed. Programs were encouraged to develop emergency funds (cash funds to assist families in meeting basic needs; hire a resource coordinator (an individual within each program designated to coordinate sources of materials and equipment for families); and to add business representatives to the advisory boards.

Grantees were required to submit copies of their interagency agreements, plans detailing how they intended to provide child care to all families needing it and written requests for any proposed changes from the contractual agreement.

ATTACHMENT 1A
FIRST CCDP GRANTEES CONFERENCE

Keynote Presentations:

Clennie Murphy, Associate Commissioner, Head Start Bureau, ACYF
Wade Horn, Ph.D., Commissioner, ACYF
Federal Welcome

Lisbeth Schorr, Author Within Our Reach
Lessons of Successful Programs for Families with Young Children

Sue Bredekamp, Director of Professional Development, NAEYC
Developmentally Appropriate Care for Infants and Toddlers

Patricia Eggleston, Ph.D., Chicago Child and Family Development Center
Issues Related to Working with Low-Income Families

Douglass R. Powell, Ph.D., Purdue University
The Challenges to Family Support Programs

General Session Presentations:

CCDP Objectives and Purpose
Allen Smith, CCDP Federal Project Officer, ACYF

Family Support Act
Marlys Gustafson, Head Start Bureau

MIS Orientation
Larry Novotney, Information Technology International (ITI)
Linda Newbern, ITI

Evaluation Contract
Soledad Sambrano, Ph.D., Project Officer, ACYF

Head Start Performance Standards for 0-3 and 3-5 Year Olds
Rita Schwarz, Head Start Bureau

Linkages with Other Community Agencies
Marvin McKinney, Ph.D., Director, Planning and Community Affairs, Mott Children's Health Center

Grants Procedures
Mary White, Supervisor, Grants Office, OHDS, DHHS

Providing Health Care Services to Low-Income Families
Phyllis Stubbs, M.D., Chief, Early Childhood Health Branch, USPHS
Georgia Buggs, Office of Minority Health, USPHS

Serving Families Affected by Substance Abuse
Randy Ratliff, Operation PAR

Needs and Issues for Future Conferences/Closing Remarks
Allen Smith, ACYF

Breakout Presentations:

Recruitment, Sampling, and Family Selection
Allen Smith, ACYF
Ruth Hubbell, Project Director, CCDP Management Support Contract, CSR,Incorporated
Larry Condelli, MIS Supervisor, CCDP Management Support Contract, CSR, Incorporated

Sharing Project Plan Overviews
Ruth Hubbell, CSR, Incorporated
Ann Kuhn, CSR, Incorporated
Judith Kimel, CSR, Incorporated
Larry Condelli, CSR, Incorporated

MIS Breakout: Discussion of Data Elements and Definitions by Program Area
Ruth Hubbell, CSR, Incorporated
Larry Condelli, CSR, Incorporated
Larry Novotney, ITI
Linda Newbern, ITI

Family Support Services
Existing Project Presentations

Early Education Models
Existing Project Presentations

Parent Education
Existing Project Presentations

Community Linkages
Existing Project Presentations

ATTACHMENT 2A

SECOND CCDP CONFERENCE AGENDA

TUESDAY, MAY 8TH

7:30-8:30 a.m.	REGISTRATION & COFFEE Washington Room Foyer				
8:30-9:30 a.m.	WELCOME & DISCUSSION OF AGENDA Washington Room	Wade Horn, Commissioner, ACYF; Clennie Murphy, Jr., Associate Commissioner, Head Start Bureau; & Allen Smith, Project Officer, CCDP			
9:30-10:00 a.m.	KEYNOTE SPEAKER Washington Room	Jule Sugarman, Founding Father of Head Start			
10:00-10:15 a.m.	BREAK Washington Room Foyer				
10:15 a.m.-12:00 p.m.	GENERAL SESSION & PANEL Washington Room	***Everything You Wanted to Know about Family Support Programs*** Gina Barclay McLaughlin, Founding Director of Beethoven Project; Roberta Clark, DC grantee; & Armena Taylor, Las Cruces, NM grantee			
12:00-1:30 p.m.	LUNCH (on your own)				
1:30-3:15 p.m.	**BREAKOUT SESSIONS A**				
	TITLE_____	***A-1: Screening & Assessment: A Framework, PART I***	***A-2: Serving Infants Affected by Drug Abuse***	***A-3: Chemical Dependency in Adults***	***A-4: Facilitating Linkages with Provider Agencies***
	SPEAKERS(S)_____	Cordelia Robinson, Winthrop College	Davene White, Howard University Hospital, Department of Pediatrics	Kate Malliarakis, National Institute on Drug Abuse (contractor)	Marie Oser, Texas Department of Human Services
	AUDIENCE(S)*.	ECC	Open	Open	PD, ETH
	FORMAT_____	Small Group	Small Group	Small Group	Small Group
	FACILITATOR_____	Ruth Hubbell	Judith Kimel	Patricia Hawkins	Hector Sanchez
	MEETING ROOM	Jackson	Washington	Plaza West	Plaza East
3:15-3:30 p.m.	BREAK Washington Room Foyer				
3:30-5:15 p.m.	**BREAKOUT SESSIONS B**				
	TITLE_____	***B-1: Screening & Assessment: Help in Selecting Instruments, PART II***	***B-2: Unit Cost Procedures***	***B-3: Chemical Dependency in Adults (repeat)***	***B-4: A Conversation with Gina Barclay McLaughlin***
	SPEAKERS(S)_____	Cordelia Robinson	Gary Bowers, Bowers & Associates	Kate Malliarakis	Gina Barclay McLaughlin
	AUDIENCE(S)*.	ECC	PD	Open	Open
	FORMAT_____	Working Group	Small Group	Small Group	Working Group
	FACILITATOR_____	Ruth Hubbell	Rita Schwartz	Judith Kimel	Dollie Wolverton
	MEETING ROOM	Jackson	Washington	Plaza West	Plaza East
5:30-7:00 p.m.	RECEPTION Potomac View Room, Penthouse Level				

* See last page of the Conference Agenda for codes for suggested audiences.

WEDNESDAY, MAY 9TH

8:00-9:00 a.m.	COFFEE Washington Room Foyer				
9:00-10:30 a.m.	**BREAKOUT SESSIONS C**				
	TITLE_____	***C-1: Important Components for Early Intervention in Infant/Toddler Programs: Training Techniques and Resources, PART I***	***C-2: How to Help Parents Gain Economic Self-Sufficiency***	***C-3: Ethnographer Training***	***C-4: Case Management Approaches & Techniques***
	SPEAKERS(S)_____	J. Ronald Lally, Far West Laboratory, Center for Child & Family Studies	Nancy McKusick, Ft. Worth, TX grantee; Gloria Rodriguez & Mercedes Perez- de Colon, San Antonio, TX grantee; & Terry Clark, KY grantee	Jerry Cline, Virginia Polytechnic Institute	Rosalyn Branson, MD grantee & Jan Martner, AZ grantee
	AUDIENCE(S)*.	ECC	Open	ETH	CMC
	FORMAT_____	Small Group	Panel	Hands-on-Training	Small Group
	FACILITATOR_____	Ruth Hubbell	Clay Roth	Sherrie Aitken	Rosalyn Branson
	MEETING ROOM	Washington	Auditorium	Jackson	Plaza West
10:30-10:45 a.m.	BREAK Washington Room Foyer				
10:45 a.m.-12:00 p.m.	**BREAKOUT SESSIONS D**				
	TITLE_____	***D-1: Important Components for Early Intervention in Infant/Toddler Programs: Training Techniques and Resources, PART II***	***D-2: Family Support Act***	***D-3: Ethnographer Training (continued)***	***D-4: Case Management Approaches & Techniques*** (continued)
	SPEAKERS(S)_____	J. Ronald Lally	Myles Schlank, HHS & Mary Ann Higgins, HHS	Jerry Cline	Rosalyn Branson, MD grantee & Jan Martner, AZ grantee
	AUDIENCE(S)*.	ECC	PD	ETH	CMC
	FORMAT_____	Small Group	Small Group	Hands-on-Training	Small Group
	FACILITATOR_____	Ruth Hubbell	Marlys Gustafson	Sherrie Aitken	Rosalyn Branson
	MEETING ROOM	Washington	Auditorium	Jackson	Plaza West
12:00-1:30 p.m.	LUNCH WITH SPEAKER Plaza East	***Lessons Learned from the Evaluation of Family Support Programs*** Heather Weiss, Harvard Family Research Project			
1:30-3:15 p.m.	**BREAKOUT SESSIONS E**				
	TITLE_____	***E-1: MIS Forms Training—Administration*** ** *Education* *Health* *Family*	***E-2: MIS Forms—Training Family*** ** *Administration* *Education* *Health*	***E-3: MIS Forms Training—Health*** ** *Family* *Administration* *Education*	***E-4: MIS Forms Training—Education*** ** *Health* *Family* *Administration*
	FORMAT_____	Small Group	Small Group	Small Group	Small Group
	FACILITATOR_____	Larry Novotney	Ruth Hubbell	Larry Condelli	David Baker
	MEETING ROOM	Washington	Auditorium	Jackson	Plaza West

3:15- 3:30 p.m.	BREAK Washington Room Foyer				
3:30- 5:15 p.m.	**BREAKOUT SESSIONS E (continued)**				
	TITLE_____	***E-1: MIS Forms Training** (continued)*	***E-2: MIS Forms Training** (continued)*	***E-3: MIS Forms Training** (continued)*	***E-4: MIS Forms Training Education** (continued)*
	MEETING ROOM	Washington	Auditorium	Jackson	Plaza West

* See last page of the Conference Agenda for codes for suggested audiences.

** Emphasis will be placed on the first topic listed in each session. Attend the session most directly related to your area of expertise.

ATTACHMENT 3A
THIRD CCDP GRANTEES MEETING

General Session Presentations:

Welcome
Allen Smith, CCDP Federal Project Officer, ACYF

Conference Overview
Ruth Hubbell, Project Director, CCDP Management Support Contract, CSR, Incorporated

Overview of MIS Operations
Larry Novotney, Information Technology International (ITI)

Closing Remarks
Allen Smith, ACYF; Ruth Hubbell, CSR, Incorporated

Breakout Presentations:

MIS Administrative Review
David Baker, ITI

Framework Review: Roles and Responsibilities of the Ethnographer
Allen Smith, ACYF

Start-Up Strategies: Grantees' Experiences
Cynthia Faust, Parent Child Resource Center, Washington, D.C.
Sebastian Striefel, Community Family Partnership, Logan, Utah
Rosalie Wells, ShareCare, Fort Worth, Texas

MIS Health Review
Richard Stec, ITI

Guidelines for Preparation of the First Ethnographer's Report
Sherrie Aitken, CSR, Incorporated
Ruth Hubbell, CSR, Incorporated

Accessing the JOBS Program
Myles Schlank, Family Support Administration

MIS Education Review
Larry Condelli, CSR, Incorporated

Sharing Research Techniques
Ethnographers

Project Directors' Meeting with the CCDP Project Officer
Allen Smith, ACYF

MIS Family Review
Linda Newbern, ITI

ATTACHMENT 4A
FOURTH CCDP GRANTEES CONFERENCE

Keynote Presentations:

Wade Horn, Ph.D., Commission, ACYF
Allen Smith, CCDP Federal Project Officer, ACYF
Welcome

Stanley Greenspan
Facilitating Parent-Child Interaction

Bernice Weissbourd, Family Focus
Family Support Programs -- The Promise of the '90s

General Session Presentations:

Family-Centered Assessment and Intervention Practices
Carl Dunst, Center for Family Studies

Status of the Impact Evaluation
Soledad Sambrano, Project Officer, ACYF
Robert St. Pierre, Impact Evaluation Contractor, Abt Associates

Team Building and New Program Implementation
Karen Gunn, Gunn Consulting Group

Wrap-Up and Adjournment
Allen Smith, ACYF
Larry Condelli, CSR, Incorporated

Breakout Presentations:

Project Directors' Meeting with Allen Smith
Allen Smith, ACYF

Child Care Provisions in the Budget Bill
Joan Lombardi, Child Care Consultant

Cultural Issues in Serving Native American Families
Beverly Graywater, Little Hoop CCDP

HIPPY Program
David Leonard, HIPPY/USA

First Data Submission Roundtable
CSR, Incorporated and ITI

Approaching Funders
Sheila Smith, Foundation for Child Development

Issues in Case Management with Low-Income Families
Wilfred Hamm, Hamm & Associates

Parent Training Programs: Coping with Kids
Mary Lee Hafley, Parenting Guidance

Working with Families
Carl Dunst, Center for Family Studies

Ensuring a Developmentally Appropriate Program: Curriculum
Diane Dodge, Teaching Strategies, Inc.

Executive Directors' Meeting with Allen Smith
Allen Smith, ACYF

Networking with the Business Community
Brenda Bell, National Alliance of Business

Ensuring a Developmentally Appropriate Program: Training
Diane Dodge, Teaching Strategies, Inc.

Programs to Prevent Childhood Malnutrition
Adwoa Steel, National Center to Prevent Malnutrition

Accessing Part H Services
Patty Biro, NECTAS

Promoting Self-Sufficiency and Economic Development
Suzanne Kindervatter and Paquita Bath, OEF International

Supervising Home Visitors
Judith Jerald, Windham County Family Support Project
Nilda Tirado, Expanded Food and Nutrition Education

Impact Evaluation: Logistical Issues
Robert St. Pierre, Abt Associates
Jean Layzer, Abt Associates
Mary Beth Sullivan, Abt Associates

Reaching Out to Males
Stanley Fuller, Family Start
Isaac Cardenas, Avance CCDP

Early Intervention with Illiterate Parents
Elena Cohen, CSR, Incorporated

Comprehensive Prenatal Programs
Margaret Haggerty, Mary's Center for Maternal and Child Health

Understanding Single Parent Families
Jacqueline Smollar, CSR, Incorporated

Starting a Volunteer Peer Support Program
Yolanda Brewster, First Friends Program

Parent-Child Interactions: Using the High Scope Model
Amy Powell, High Scope Education and Research Foundation

Dealing with Child Maltreatment Issues
Carmen Robles-Gordon, Mayor's Committee on Child Abuse and Neglect

Interagency Coordination
Jorja Knudsen, Families in Partnership
Cherylee Sherry, Project CHANCE
Michaelle Ann Robinson, Community-Family Partnership project

Accessing Resources for Low-Income Families
Joan Lauver, West CAP Full Circle Project
Bob Rosa, Avance CCDP

ATTACHMENT 5A

FRAMEWORK FOR CASE STUDIES

The purpose of the case studies (studies of CCDP projects) is to provide a narrative description of each project to supplement and explain the Management Information System (MIS) data. The primary questions which must be answered by both the case studies and the MIS focus on CCDP program feasibility and family utilization of services. **While the MIS data will help us to explain the numbers and demographic characteristics of participating families and the services provided by grantees and cooperating agencies, it will not explain why some families participate more extensively than others or what community and program factors facilitate or impede family utilization of services.** Research will be most valuable in revealing unexpected, complex, intangible, and subtle factors which explain family utilization and program feasibility.

The framework in this paper is intended to provide an overall conceptual model for the researcher's efforts. Case studies done at each of the twenty-four sites will address the same topics and questions allowing for some comparison among cases.

Researchers at all sites will be asked to write four reports over a one year period. Guidelines for presentation of the material in each of these reports will be provided, including suggestions for sources of information to utilize in carrying out research. (See attached Guidelines for First Report). It is not expected that any one of these four reports will cover all of the questions listed in this framework. Rather, selected topics and questions from this framework will be identified for inclusion in each of the reports.

In addition to the common guidelines, the use of an ecological perspective from which to view CCDP families is suggested. An ecological perspective assumes the following: all parts are related and the whole is greater than the sum of its parts; there is constant reciprocity and mutual accommodation within and between each system/level; and each system/level as well as the total system strives to maintain an equilibrium.

It is proposed that the CCDP researchers focus on four domains in examining the factors involved in family utilization and program feasibility: community, the service network, CCDP program/service delivery, and the family. The four domains can be conceptualized as four concentric circles as shown below:

Use of this perspective provides a framework for examining the complexity and interrelatedness of the many factors involved in starting a new community-based program such as CCDP. The effect of change, barriers, or facilitative factors on one domain can be traced as it reverberates through other domains.

A discussion of the relevant questions/issues that researchers may focus on at each domain of this ecological framework follows: while this listing is not intended to be all inclusive, it provides examples of salient issues which may be pertinent within and across domains. We have not ranked these issues, but those with asterisks are to be considered a high priority.

Domain 1: Community

At the community level the focus is on the sociological, economic, and political context within which the local CCDP operates and how these contextual factors operate to constrain or facilitate CCDP program feasibility and family utilization.

Areas of exploration include the following:

- *• What are the dominant political and social issues (i.e., major social problems) in the community, and how have these issues affected the services and support networks existing prior to the CCDP?
- *• What kinds of community support or resistance for CCDP exist, and what are the reasons for this support or resistance? How has CCDP dealt with these resistances?
- *• What is the extent of advocacy efforts for CCDP in the community?
- • What is the magnitude, distribution, and character of poverty families in the community? Have there been changes over the course of the project that are relevant to the development of the project?
- • Is there an expanding, receding, or stagnant economic base in the community, and how does this impact on employment, affordable housing, public support for social services to low income populations?
- • What is the availability of and access to educational resources (i.e., vocational or special education) for families similar to those in CCDP?
- • What are the current community issues related to crime, drugs, school dropouts, teen pregnancy, housing, transportation, recreation, sanitation, and pollution? How do the community strengths or weaknesses in these areas impact on CCDP families and the CCDP service delivery system?
- • What are the values, culture, and norms of the CCDP's target population(s) (i.e., racial, class, religious, and ethnic)? For example, what are the cultural values about economic independence, adolescent pregnancy, or education? What implications do these values, cultures, and norms have on CCDP program feasibility and family utilization?

Domain 2: Service Network

Federal legislation pertaining to the Comprehensive Child Development Program specifies that each of the CCDP's shall provide intensive, comprehensive, integrated, and continuous services to families. In order to fulfill this mandate, the CCDP must provide active leadership in bringing the education, social, and health services together to coordinate and facilitate the delivery of services.

Researchers need to explore the extent to which and the conditions under which such a system of coordinated comprehensive service delivery is being implemented. Methodologies can be used to

explore the steps, strategies, and systems which have been and are being used for these purposes as well as the barriers and facilitators encountered in this process at each site.

The following questions are relevant to exploration of the service network:

- What were the characteristics and relationships of the service network (public and private) for low income families prior to the start of the CCDP (i.e., political factors, turf issues)?
- How much coordination/interaction between CCDP-involved agencies currently occurs, and at what levels (i.e., staff, administrative)? What mechanisms are used to facilitate this coordination (i.e., interagency agreements, advisory boards)? Do agencies share common standards such as eligibility criteria, assessment tools or personnel?
- How much difficulty has the CCDP faced or is it currently facing in bringing about coordination among the current community agencies? What types of barriers have been encountered? For which agencies?
- What is the availability of services (child care, early childhood education, health care, social services, substance abuse treatment, vocational training) for poverty families in the community?
- What are the perceptions and attitudes of community agencies toward the CCDP and its goals? What is the level of commitment on the part of participating agencies to CCDP?
- Are advisory board meetings well attended? Is there active participation among representatives on important issues affecting CCDP policy?
- How does the CCDP case management system interface with other similar approaches to service delivery coordination in the community? Does it result in increased integration, fragmentation, or duplication of case management efforts in the community?
- Has the CCDP service network made any efforts to link itself with the business community? What process has been used for this purpose and what have been the results?

Domain 3: CCDP Program/Service Delivery

This level focuses on three aspects of the CCDP itself: program goals, program organization and management, and service delivery model/system. Questions that need to be answered at this level revolve around issues of program feasibility, that is whether all of the various components involved in implementing a family support program for low income families can reasonably be put in place, and what are the barriers in this process?

Potential areas of exploration under each of the three aspects of the CCDP program are as follows:

CCDP Goals/Philosophy

- What are the CCDP program goals?
- Is there a differential emphasis on each of these goals?

Program Organization and Management

- How is the CCDP program administratively related to the broader umbrella agency if there is one? What are the relationships between the CCDP program and the larger agency?
- What is the basic organizational structure of the CCDP?

- How are the policy and/or advisory boards structured and what impact do they have on program operations?
- Are mechanisms set up for internal coordination among separate program components—staff and administration, coordinators and data manager?

Service Delivery Model/System

- What are the key components of the delivery of the CCDP core services (i.e., home based, center-based, parent support groups)? Services provided directly by the grantee, by contract or other organizations? By cooperating agencies?
- How were program start-up tasks organized, and what processes were used to work toward start-up goals? What barriers were encountered and how were these overcome?
- How were staff members recruited?
- What kind of training is provided to key service and support staff? Is it appropriate?
- Was enough time provided to program for start-up and was enough support and assistance provided by "Washington" (i.e., national level resources)?
- How does the program deal with staff burnout and turnover?
- Is the program sensitive to the values, life styles, and socioeconomic conditions of the target population(s) it serves? If so, in what ways (i.e., training, accessibility of services, service delivery strategies, matching service provider and family)?
- Are programs internally monitored and evaluated on an ongoing basis? If so, describe this process. How are result used for making changes?
- How is the role of the case manager defined and implemented in this project? Are caseloads and tasks seen as appropriate or are there tensions between the two? How do case managers perceive their role?

Domain 4: Families

When viewing the family, researchers should focus on family participation, satisfaction, and tenure in the program. An understanding of these factors will serve to explain the MIS data. For example, why do some families participate in some activities and not others, or why do some families participate more extensively than others? What individual or family factors facilitate or impede this participation? Some of these factors may be subtle ones, observable only in day-to-day interactions of families at the program or gleaned from talks with the families themselves or from the staff working with them. Researchers may focus on purposive (not necessarily random) samples of families to understand their behaviors.

Areas for potential examination at this level include the following:

- What are family and extended family perceptions and expectations of the CCDP program; how and why do these perceptions change over time? What are the family's perceptions of what is helpful and empowering for them? How is CCDP affecting family goals and expectations toward reaching those goals?
- What family and individual factors appear to reinforce or discourage parental participation? What factors do families perceive as inhibiting or facilitating their participation (i.e., access, program factors, staff factors, individual personality factors)?
- Are some families more appropriately served by some programs rather than others, and why?
- What qualitative factors characterize recruited families (e.g., level of isolation, independence, work ethic, immigrants)?

- What are the various forms and patterns of parental participation in the CCDP? Which individual/family characteristics influence these various forms of participation? What tensions exist for families in regard to participating in varying program components?
- What are some examples of family successes as a result of CCDP participation? What are examples of families CCDP was not able to help and why?
- How do family developmental stage, environmental stress, informal network support, family boundaries in dealing with the outside environment, and family coping strategies impact participation?
- Why do families leave the program, and how are their reasons for leaving fed back to the program?
- Are there any unintended (negative or positive) consequences for families as a result of their participation?

ATTACHMENT 6A

GUIDELINES FOR THE FIRST REPORT

Four reports of about 25-30 pages each are planned for the coming 12 months. These reports will build upon each other to describe the project as it develops. Development of these reports will enable the researchers to become thoroughly familiar with the community, program operations and families. The report should address the questions listed below in a narrative format.

Three major topics are planned for the first report—Planning/Start-up Activities, Program Goals/Systems and Organization, and Contextual Issues. All three should be covered, but priority should be given to Project Planning/Start-up Activities. Because these activities are quite recent, it would be appropriate to cover them now; in addition, as time goes on it will be more difficult to recall and capture the key issues and critical dynamics which were part of project start-up activities.

The following are the guidelines for the first report:

I. Project Planning/Start-up Activities

The focus in this section should be on the processes, barriers, facilitators, and key elements involved in the major CCDP planning activities i.e., hiring staff; recruitment of families; working with advisory committee and policy boards; dissemination activities; development of community linkages and planning with community agencies; facility/space issues; training plans; creation of forms, policies and procedures; process of obtaining community support for CCDP; and staff planning of goals and program components.

Researchers should include the following questions in their analysis:

- How were program start-up tasks organized, and what processes were used to work toward start-up goals: What barriers were encountered and how were these overcome? (Include recruitment processes, advisory board involvement, hiring, efforts to obtain facilities/space, training for staff, staff involvement/planning processes, development of CCDP policies/procedures, and obtaining community support for CCDP).

- What is the availability of services (child care, early childhood education, health, social services, substance abuse treatment, vocational training, etc.) for poverty families in the community?

II. Program Goals/Systems and Organization

The second section of the report should address program goals, systems and organization.

CCDP Goals/Philosophy

- What are the CCDP program goals?
- Is there a differential emphasis on each of these goals?

Program Organization and Management

- How is the CCDP program administratively related to the broader umbrella agency if there is one? What are the relationships between the CCDP program and the larger agency?

- What is the basic organizational structure of the CCDP?
- How are the policy and/or advisory boards structured and what impact do they have on program operations?
- Are mechanisms set up for internal coordination among separate program components—staff and administration, coordinators and data manager?

Service Delivery Model/System

- What are the key components of the delivery of the CCDP core services (i.e., home based, center-based, parent support groups)? Services provided directly by the grantee, by contract or other organizations? By cooperating agencies?
- How were program start-up tasks organized, and what processes were used to work toward start-up goals? What barriers were encountered and how were these overcome?
- How were staff members recruited?
- What kind of training is provided to key service and support staff? Is it appropriate?
- Was enough time provided to program for start-up and was enough support and assistance provided by "Washington" (i.e., national level resources)?

III. Contextual Issues

This section should focus on two areas: the social, economic, and political issues of the community as they impact on the CCDP families and the CCDP families served.

Areas of exploration should include the following:

- What is the magnitude, distribution, and character of poverty families in the community?
- What are the qualitative characteristics (i.e., isolated, independent, work ethic, immigrants) of recruited families, and how do these families differ from those who declined to participate after recruitment interviews?
- What are the dominant political and social issues in the community, and how have these issues affected services and support networks existing prior to the CCDP? E.g, Is there an expanding, receding, or stagnant economic base in the community, and how does this impact on employment, affordable housing, public support for social services to low income populations?

The following are possible sources of information which may be used to gather material these activities; additional sources may also be used:

- Interviews with CCDP staff (administrative, coordinator/service)
- CCDP proposal
- Quarterly progress reports
- Interviews with involved community agency staff
- Newspapers
- CCDP proposal (target population characteristics)
- Application for refunding (when available)
- Advisory board minutes/agendas
- Minutes of CCDP staff planning meetings or committee meetings
- Correspondence

- Observation of advisory board meeting
- Written planning documents or recruitment plans
- Interview with parents and/or community leaders involved in planning process
- Observation of CCDP service provision

The report should follow this outline:

I. Introduction—identification of project, brief overview of community, families, and service delivery model (two paragraphs).

II. Methodology—data collection and analysis techniques used by researcher to develop this report (less than 5 pages).

III. Findings

A. Contextual Issues

Narrative response to questions above (up to 10 pages).

B. Program Goals/Systems and Organization

Narrative response to questions above (up to 10 pages).

C. Planning/Startup Issues

Narrative response to questions above (up to 10 pages)

APPENDIX II

PROGRAM PROFILES

Project AFRIC (Advancement For Families Rich In Children)

Grantee Agency

Dimock Community Health Center

Geographic Service Area

The Roxbury section of Boston, Massachusetts

Number of Families Served

120 families are served.

Program Philosophy

Project AFRIC's philosophy centers around Family Empowerment, with the intended result being the development of well-informed, motivated, and self-directed families.

Services provided and how they are delivered

Adults:

Health services

Health care is provided for adults through Dimock Community Health Center, Boston City Hospital, Martha Eliot Health Center, and other health facilities in the area.

Education, vocational training, employment counseling

Employment counseling is provided by Dimock Community Health Center. Vocational training is provided by Dimock, Veteran's Benefit Clearinghouse, Aswalos House/Roxbury YWCA, and Bromley-Heath Tenanat Management Corporation. Bi-lingual education and employment counseling are provided by La Alianza Hispaña. Roxbury Community College, United South End Settlements, and Boston Community Schools provide Adult Basic Education and GED preparation.

Training in infant/child development, health care, nutrition, and parenting

Training in infant/child development, health care, nutrition and parenting is provided to parents at the Project AFRIC center through workshops and group discussion. Topics covered include effective parenting techniques, appropriate play activities for infants and young children, stress management and developing positive self-esteem, balanced meal planning and cost-effective menu planning.

Assistance with housing, income support, nutrition

The AFRIC institutional network, state and city agencies (i.e. Department of Social Services, Department of Health & Hospitals, Boston Public Schools, Roxbury Community College) work with AFRIC staff and community-based agencies to provide access to existing services. The committee for Boston Public Housing provides outreach, translation services, injury prevention information, and distribution of home safety devices. Nutritionists at WIC provide nutritional assessments and counseling.

Substance abuse education and treatment

Substance abuse treatment is provided through Dimock Community Health Center, which includes outpatient counseling, inpatient detoxification, a residential halfway house for men and women, and acupuncture treatment coupled with therapy. Substance abuse treatment is available as well through a program at Boston City Hospital. Mental Health services are provided through the Camille Cosby Center for Mental Health.

Children:

Health services

Dimock Community Health Center and Martha Eliot Health Center provide primary health care for children (routine medical check-ups). Referrals are made to Boston City Hospital for cases of acute illness.

Early childhood experiences

Project AFRIC's Early Childhood Education Coordinator has developed a curriculum to be used by Family Advisors. Family Advisors provide an appropriate developmental experience to children in the home when they conduct home visits.

Child care

Paige Academy provides care for infants, toddlers, preschoolers and five to six year old children entering kindergarten. Educational emphasis is on developing self-esteem, self-sufficiency and mastery of basic education and social skills. There are 42 slots allocated for Project AFRIC. A day care center is being run at the project center as well for drop-in care.

Early intervention for developmental delays

The Early Intervention Program at Dimock, with its multi-disciplinary staff, provides home-based and center-based services to families with special needs, developmentally

at risk or environmentally at risk children 0 to 3 years old. The services are combinations of supportive and therapeutic activities individualized to the family and child. Paige Academy provides early intervention services as well.

Nutrition

WIC and nutrition needs are assessed by the Family Advisors and medical personnel. After the initial screening and determination, services are provided by existing and expanded programs at Dimock Community Health Center, Boston City Hospital, Martha Eliot Health Center, and Paige Academy.

Windham County Family Support Project (WCFSP)

Grantee Agency

Brattleboro Town School District

Geographic Service Area

Windham County in the southeast Corner of Vermont, including Bellow Falls, New Fane, and Brattleboro

Number of Families Served

60 families are served.

Program Philosophy

WCFSP is designed to counteract many factors that place poor children at risk of adverse development. The project achieves this by promoting improved family functioning and family self-sufficiency by addressing a host of specific developmental and support needs for children, parents, and other family members. These needs are met through a home-based model in which lay professional home visitors serve as key family support staff; an interdisciplinary team of 2 early education specialists, nurse/health coordinator and social worker work closely with home visitors to assure comprehensive service delivery and community collaboration.

Services provided and how are they delivered

Adults:

Health services

Health and dental services are provided to all participants by private providers under Medicaid. The Vermont Health Department and WCFSP have a collaborative arrangement to provide health services to pregnant women through the Medicaid Outreach Program. The program prioritizes pregnant women under 21 years of age. Women over 21 years are screened for risk factors and to determine followup needs. The WCFSP health coordinator screens the members of the family and works with them during home visits to ensure preventive health care.

Education, vocational training, employment counseling

The home visitor and case manager coordinator identify, support and refer family members for career counseling, education, vocational training and employment to the Southeastern Vermont Career Center, State Department of Employment and Training, and the Employment Group. Businesses are represented on the advisory board.

WCFSP helps participants identify career paths which are personally and financially rewarding. The Employment Group has established that parents need jobs paying a minimum of $7.50 an hour to equal the benefits they are receiving from welfare. WCFSP has told participants who desire to enhance their vocational choice through education, that financial support for classes leading to advanced degrees is possible.

Training in infant/child development, health care, nutrition, and parenting

Training is provided through a multifaceted approach. The home visitors provide weekly training during their visits; the nurse/health coordinator works with individual families with their health care needs; the Vermont Public Health Department provides classes in nutritional needs of mother and child, breast or bottle feeding techniques, benefits of breastfeeding, growth and development, health care and immunization, child safety, family relationships, family planning, meal planning, and diet and weight gain. WCFSP also provides weekly workshops for parents on these topics in small support group settings.

Assistance with housing, income support, nutrition

Home visitors and the social worker work closely with the Department of Social Welfare and the Vermont Department of Health to insure participants are aware of programs in the community to meet these needs.

Substance abuse education and treatment

WCFSP social worker presents classes to parents and works with parents who have this need. She coordinates services with local treatment centers and with the Vermont Department of Alcohol Abuse Prevention as well as WIC classes on the effects of alcohol and smoking during pregnancy.

Other services

The Community Action of Brattleboro, a collaborating agency, offers legal aid services, tax assistance, pro se divorce documents and financial management services. WCFSP provides family development workshops, weekly parent educational meetings, support groups and is developing a male participation program.

Children:

Health services

Health and dental services are provided by private providers under Medicaid. In addition, the Vermont Health Department provides WIC food, fluoridation, handicapped children's services, Tooth Fairy Program, well child clinics, and immunizations.

Early childhood experiences

Early education services are the central program focus with three major components: weekly home visits for children 0-5 years old; weekly developmental play groups for children 1-2 years old; and preschool programs for children 3-4 years old. An eclectic curriculum designed by the early childhood coordinator is used. Individual plans are designed for each child. For those children who are school age (5-17), WCFSP advocates for the children with the school. A team of 8 home visitors, and 2 early childhood specialists coordinate and direct this part of the program.

Child care

WCFSP helped establish, through a collaborative agreement with the Brattleboro Union High School and Southeastern Vermont Career Center, an infant center so that child care was available to infants and toddlers of teen parents who want to finish high school. WCFSP has a collaborative agreement with the Prouty Center for 50 child care slots (0-5) and classes are provided for the age appropriate care. There exists 31 child care centers in the county and 74 registered day care homes. Windham County Day Care Association, a collaborating agency keeps an updated list of availability. WCFSP has provided training for family day care homes in Windham County.

Early intervention for developmental delays

All children are screened twice a year (0-3) and annually thereafter to assess risk of developmental delay. Children identified as at risk of delay are referred to the Winston Prouty Center, where an intervention plan is developed and collaboratively implemented. Children receive therapy at the Winston Prouty Center as well as in their homes. The WCFSP staff is part of the therapeutic team and is responsible for supporting parents in implementing and following through on planned intervention. The project uses speech and physical therapists and psychological services on a consulting basis.

Nutrition

WCFSP has a collaborative agreement with the Vermont Health Department which provides WIC services. The project nurse and home visitors provide parent nutrition education on an ongoing basis, individually during home visits and during group workshops.

Other services

WCFSP provides for the enhancement of the child's environment in the Brattleboro area by sponsoring Child Development Workshops for child care providers and educators. WCFSP in a joint effort is sponsoring and running a summer camp program for 4-6 year old participants.

Project CHANCE (Center to Help Advance Neighborhood Children's Education)

Grantee Agency

Project Teen Aid

Geographic Service Area

Whitman public housing complexes in the Fort Greene area of Brooklyn, New York

Number of Families Served

120 families are served.

Program Philosophy

In working with families, program staff utilize the Community of Caring model which emphasizes the need to understand the unique and universal family values of the families being served. The objectives of the project include the following: (1) helping parents become more knowledgeable of their children's development and emerging skills so that they can prepare them to enter elementary school on par with children from more affluent neighborhoods, (2) empowering family members to make responsible choices by building self-esteem of both adults and children, (3) teaching the skills necessary to negotiate the complex service system, and (4) offering good health education and employment, thereby moving families toward self-sufficiency.

Services provided and how they are delivered

Adults:

Health services

Most of the core health services are delivered by a cooperating agency, Cumberland Family Care Clinic (CFCC). CFCC provides complete physical examinations, routine diagnostic laboratory work and dental screenings.

Educational, vocational training, employment counseling

The project has networked with community agencies to provide education and vocational training and employment counseling. A community center and a local high school and Technical College offer course work leading to a GED. Arrangements have been made with Automotive High School to provide vocational training in auto mechanics and with Colony South Brooklyn House to provide employment counseling.

Training in infant/child development, health care, nutrition and parenting

Parent education is provided to adult family members during home visits. The project also is developing a group parent training program using the Head Start curricula. The parent program has 4 components and includes parent and life education; center-based activities; work related issues; and a father's program. Cornell University Cooperative Extension Services provides this training and also supports a program team leader.

Assistance with housing, income support, nutrition

Nutritional services are available through WIC, which is located in CFCC. Case managers are responsible for assisting families in obtaining income support and addressing housing needs.

Substance abuse education and treatment

CFCC also operates an outpatient, chemical dependency program to which program families are referred by CFCC physicians. If a person is currently abusing alcohol or other drugs they are referred to Woodhull hospital.

Other services

Other services are provided by existing community agencies. For instance, families are referred to the Salvation Army and Holy Trinity to obtain clothing and food and to the community center for summer recreational activities.

Children:

Health services

CFCC also provides health services to children that include, but are not limited to physical examinations, well-baby and sick care, dental and mental health services and maternal and child health.

Early childhood experiences

Early childhood educational services for CCDP infants and children are provided by outreach workers during home visits. The outreach workers utilize the *Hawaii Early Learning Profile (HELP)* curriculum for home-based activities. A drop-in center also provides early childhood services. Outreach workers and neighborhood assistance team members visit families together to provide early childhood and case management services.

Child care

The umbrella agency, Project Teen Aid, operates a day care center into which some Project CHANCE children and infants can be placed. The project also uses family day care homes and is currently in the process of licensing space for child care for 20 infants/toddlers.

Early intervention for development delays

Developmental assessments utilizing the *HELP* tool are conducted by outreach workers during home visits. Developmental charts are used to follow a child's progression and to plan appropriate activities.

Nutrition

Nutritional services are provided through WIC.

Parent Child Resource Center (PCRC)

Grantee Agency

Edward C. Mazique Parent Child Center, Inc.

Geographic Service Area

Wards 1, 2, 7, and 8 of Washington, D.C.

Number of Families Served

160 families are served.

Program Philosophy

PCRC uses an empowerment model that is based on two key components: (1) longstanding, organizational linkages with community social service systems, and (2) one-on-one, non-judgmental relationships with client families. The project treats empowerment as a holistic aim that begins by helping program parents to know that they have power and rights to be involved as parents. This philosophy also includes raising families' awareness of how they can impact their communities through activism.

Services provided and how they are delivered

Adults:

Health services

Both of the project's sites are located on the premises of Community Health Care, Inc. (CHCI), a local, non-profit health care cooperation. Community Health Care is the primary provider for PCRC families' comprehensive medical care, including routine, prenatal, dental, and mental health care. The project also has agreements with Howard University, to expedite admissions and billing for hospitalized PCRC family members, and with the D.C. Commission on Public Health (CPH), Office of Maternal and Child Health, to link parents with their prenatal and mental health programs. Other health services, such as dentistry, gynecology, family planning, and nutrition services are provided through an agreement with the CPH Neighborhood Health Centers. Individual and family mental health counseling is provided on-site by two mental health counselors employed by the project.

Educational, vocational training, and employment counseling

The project's Employment, Education, and Training Coordinator refers families to appropriate adult education/job training programs and places them in jobs.

Training in infant/child development, health care, nutrition, and parenting

Center-based, group training is provided to parents through the REACH Program of the National Children's Medical Center, Even Start Program (for Hispanic families), and in workshops at the center provided by PCRC consultants. Home-based training is provided as appropriate during home visits by the case coordinators (CCs); CCs also provide hands-on modeling of a child development activity during regular home visits.

Assistance with housing, income support, nutrition

CCs broker services and advocate for families in their caseloads to meet needs identified by the family during home visits.

Substance abuse education and treatment

Inpatient and outpatient substance abuse treatment programs are available in Wards 1, 2, 7, and 8 through the CPH Alcohol and Drug Abuse Services Administration (ADASA). The two mental health counselors on-site also provide substance abuse counseling.

Other services

An agreement with the Division of Child Protection, Children's National Medical Center (REACH Program) provides for parenting education and assistance with specialty child protection issues upon referral.

Children:

Health services

Pediatric care, dental care, and immunizations are provided through CHCI and the CPH Neighborhood Health Centers.

Early childhood experiences

CCs provide early childhood educational experiences during regular home visits. Some children also receive developmental experiences at their child care center, the Edward C. Mazique Parent Child Center (the grantee agency center), or through Head Start.

Child care

The Mazique Center provides care to some PCRC children. Additional slots are purchased from family day care homes, cooperating or contracted day care centers, and relative care.

Early intervention for developmental delays

All children aged 3 and under are screened by the project director using the *Hawaii Early Learning Profile (HELP)* all children 4 and 5 years old are screened using the *Learning Accomplishment Profile* (LAP). Children with suspected delays are referred for further testing to the Children's Hearing and Speech Center (at the Scottish Rite Center for Childhood Language Disorders), a cooperating agency that provides diagnostic evaluations and intervention for speech, language and hearing disorders. Intervention may be provided by the Children's Hearing and Speech Center, the Edward C. Mazique Center, or by the case coordinators using special curricula.

Family Start

Grantee Agency

Friends of the Family, Inc.

Geographic Service Area

Lower Park Heights and Upton communities of Baltimore, Maryland

Number of Families Served

120 families are served

Program Philosophy

"One cannot give what one does not have." Family Start nurtures parents and assists them with their basic needs so that they can nurture their children. Family Start builds upon family strengths, empowers families to become their own best advocates, and views children, families, and communities holistically.

Services provided and how are they delivered

Adults:

Health services

Health services are provided by a variety of individual providers and community clinics for those ineligible for Medicaid. University of Maryland nursing students assist case managers on selected cases. Access and referral to prenatal care is provided through relationships with Baltimore City Health Department, hospitals, community health centers, WIC, community health nurses, and other programs. In-center prenatal education and exercise groups are also conducted. Home visits also provide education and referral assistance with prenatal care.

Education, vocational training, employment counseling

Family Start has an agreement with the City of Baltimore Office of Employment Development to refer family members for remedial education, job skill training, job readiness, job development and placement, job search, and on-the-job training. In addition, Family Start has a self-employment specialist who assists participants in gaining access to training programs and starting their own businesses. Also, GED, ABE, and literacy programs are conducted at the three centers.

Training in infant/child development, health care, nutrition, and parenting

Ongoing parent education groups and parent support groups are held at the three centers. Health education groups are also conducted at the centers.

Assistance with housing, income support, nutrition

Families are assisted in working with the City Department of Social Services. In addition, there is a focus on education on rights to child support as well as emergency fund monies allotted for each family. Also, transitional housing and shelter programs are available.

Substance abuse education and treatment

Family Start staff have expertise in substance abuse and assist with referral to the University of Maryland's outpatient Alcohol and Drug Abuse Program as well as other community-based programs.

Other services

There is a resource coordinator to identify community needs/services, and facilitate linkages and a council of service providers to improve access/responsiveness of services. The project provides recreational opportunities for families and assistance in transition to elementary school. The project operates a separate Male Program to involve fathers.

Children:

Health services

Children receive health care through individual providers and community-based hospitals and clinics. The University of Maryland and community health nurses in coordination with case managers provide additional assessment and support. Families are given "Medical Passports" to record medical care.

Early childhood experiences

Child development staff assess children. Home- and center-based programming are both available. Family friends (case managers) carry out home-based activities for parents whose children do not attend a center or a drop-in program. Drop-in centers with developmentally appropriate curriculum are available at three sites.

Child care

The project guarantees day care through Project Independence. The project is campaigning to increase day care in the communities it serves and link prospective providers to a special program for start-up funding and technical assistance. The project uses an infant group care center in Park Heights and offers training programs for care providers. Temporary child care (while the parents are on-site) in family support centers is available as are expanded Head Start opportunities. Family friends assist with information and referrals regarding the location of family day care providers.

Early intervention for developmental delays

Initial screening of babies and regular developmental assessments are conducted by the Child Development Specialist. Contractual arrangements exist with Parents and Children Together, an agency serving children with developmental delays, and the Hearing and Speech Agency. There is a linkage to Child Find for educational services. Advocacy, referrals, transportation are provided to families as needed.

Nutrition

The project provides nutritious lunches to children at the center. Project participants are involved in the meal preparation. The project also provides cooking demonstrations and nutrition workshops. The project promotes breastfeeding. Family friends occasionally shop and/or cook with parents. WIC services are available to families.

Family Foundations

Grantee Agency

University of Pittsburgh

Geographic Service Area

The communities of Clairton and Sto-Rox, and a city neighborhood, Terrace Village, in the Pittsburgh, Pennsylvania area

Number of Families Served

120 families are served.

Program Philosophy

The approach used in developing and implementing this project is based on a strengths-oriented family support model. The model used is a team approach including the parent, family advocate (child development) and case manager. This team allows for child development activities, as well as family access and choices to use resources from other agencies when needed. A key is the opportunity to develop validating relationships with peers, professionals and paraprofessionals while providing learning opportunities which enhance skill development for family members. This model focuses on quality, effectiveness and efficiency. The program is of high quality because family empowerment, case management and Parent Council involvement keep it responsive; in addition, it uses only licensed programs that meet quality standards.

Services provided and how are they delivered

Adults:

Health services

CCDP families may utilize neighborhood clinics, obstetricians, and other health providers as they wish. The case manager initially assesses family health needs and then reviews each family's health situation with a public health nurse assigned to each site. Referrals then are made to the public health nurse, CCDP nutritionist, or other providers. Pre/postnatal services are provided by the public health nurse.

Education, vocational training, employment counseling

Family members are referred to the Department of Public Assistance—Single Point of Contact Program (SPOC)-for assessment, education, training, and counseling. In addition, basic literacy, adult basic education, and GED preparation are available through programs at the sites.

Training in infant/child development, health care, nutrition, and parenting

Parent education groups in the above areas are provided by members of the interdisciplinary team at each site. Workshops, support groups and on-going parent education groups are available at all three sites.

Assistance with housing, income support, nutrition

Social service assistance (AFDC, Medicaid, Food Stamps) is available through the Department of Public Assistance. A CCDP contract with the Urban League provides emergency assistance especially in the area of housing needs. The CCDP nutritionist is available to all families for both home-based and center-based services. WIC services also are available for eligible families in or near the targeted communities.

Substance abuse education and treatment

Each site is served by a substance abuse prevention specialist one day a week. This specialist is involved in assessment, short-term treatment, referral, and parent education prevention groups.

Other services

This program also provides an Individual Family Service Plan (IFSP) for each family. The case managers use the IFSP to link families to services and provide ongoing support for service usage. The community organizer conducts community outreach activities that promote community support including a drop-in center and the development of the Parents Council. The Parents Council is provided with a discretionary fund.

Children:

Health services

The case manager and public health nurse assess and review each family/child's health needs. Infants under three months are seen by the public health nurse. Families may utilize neighborhood clinics, obstetricians, and other health providers.

Early childhood experiences

Families Facing the Future, an in-home child development program, provides a family advocate and a child development specialist for each family. In addition, Head Start classes, center-based parent/child development groups and developmental preschools are available to families.

Child care

The case manager assists families in obtaining child care which is available through a variety of licensed family day care homes and day care centers. Funding for child care is provided primarily by SPOC, JTPA, and Title XX programs. Drop-in care is also available at each of the three sites.

Early intervention for developmental delays

Children identified with a developmental delays are referred to St. Peter's Child Development Center or the Association for Retarded Children. An early intervention specialist also is available in all three neighborhoods through the Families Facing the Future Program. The specialist assesses and provides programming for children who do not qualify for existing early intervention programs.

Nutrition

Nutritional services include education, assessment, feeding programs, and WIC. A nutritionist and public health nurses are part of the team providing these services in home and/or in center-based education groups.

Project T.I.P.P. (Toddlers, Infants, Preschoolers and Parents)

Grantee Agency

Dade County Community Action Agency

Geographic Service Area

North Central Dade County, Florida, including portions of the City of Miami, unincorporated Dade County, and well-known ethnic neighborhoods such as Brownsville, Liberty City, Little Haiti, and West Little River

Number of Families Served

120 families are served.

Program Philosophy

The program is organized around an approach that seeks to foster the development of children by enhancing the parent's child rearing capacities, building on the family's strengths, and enhancing the community context in which children grow up.

Services provided and how are they delivered

Adults:

Health services

Appropriate health services are coordinated with existing neighborhood providers which include, but are not limited to, the Liberty City Health Center, the Family Health Center, Jackson Memorial Hospital, family counseling services, and the University of Miami Mailman Center. Services include the following: prenatal and postpartum care, birth control and family planning, routine primary health services, nutrition counseling, drug/alcohol treatment, and mental health. Health education and prevention also are emphasized by Project T.I.P.P.'s Health Coordinator.

Education, vocational training, employment counseling

Economic and career development services include in-depth assessments for appropriate referrals for continuing or remedial education, vocational training, employability skills training and job placement. Major providers of these services include the Dade County Schools, the Private Industry Council Service Providers, local community colleges and universities, and the State of Florida Job Service. community.

Training in infant/child development, health care, nutrition, and parenting

Individual and group trainings are provided by Project T.I.P.P. staff and other service providers, such as Family Counseling, the Mailman Center and Miami-Dade Community College. These sessions are provided at Project T.I.P.P. headquarters, and in the homes and/or other neighborhood locations.

Assistance with housing, income support, nutrition

Assistance with housing is provided by the Department of Housing and Urban Development. The Department of Health and Rehabilitation provides income support and nutrition (WIC) services. For emergency situations, income support is provided by the Department of Human Resources of Dade County.

Substance abuse education and treatment

The Dade County Department of Human Resources and other non-profit agencies provide substance abuse education and treatment.

Other services

Project T.I.P.P. is leasing a van and negotiating with the Metro Dade Transit Agency to purchase passes at reduced cost. Volunteers are solicited to provide workshops in financial planning/budgeting. Social groups in the community volunteer to provide workshops to build self-esteem.

Children:

Health services

All services including well baby clinics, immunizations, routine and acute care and dental care are provided at local community health centers and Jackson Memorial Hospital.

Early childhood experiences

Early childhood experiences are provided at T.I.P.P.'s Children's Center as well as during the weekly home visits. Other individual and agency volunteers provide more specialized services as warranted.

Child care

The Children's Center provides and/or coordinates for the provision of child care and child development services. The Children's Center located at Project T.I.P.P. headquarters operates five days per week. Up to 40 infant and toddler slots are

provided by Project T.I.P.P. on-site and other slots are contracted through the Urban League and other providers. Head Start provides slots for the 3 to 5 year old children in the service area. Initially, the child care slots at Project T.I.P.P. are being utilized for child development activities and part-time child care for caregivers who are involved in educational and training workshops or other approved activities related to the family's well-being. If the infant care need exceeds the Children's center slots, other infant care is arranged through the purchase of service agreements with Title XX providers or other private providers.

Early intervention for developmental delays

Children with special needs, including those who are deaf, cocaine addicted, visually impaired or HIV positive are screened by Project T.I.P.P. staff, the Florida Diagnostic Learning Resources Systems (FDLRS) and the University of Miami Center for Child Development. A full range of health and related services are provided by the Mailman Center or members of the South Florida Perinatal Network that serve the developmentally disabled.

Nutrition

Nutritional assistance is provided through WIC with the Department of Health and Rehabilitation. The project provides nutrition information to parents. Those children who use the child care center also receive meals that meet Federal nutrition requirements.

Other services

Special events and activities are planned for children, such as trips to the circus, museums, movies, family picnics and a Christmas Party.

Operation Family

Grantee Agency

Community Action Council of Lexington-Fayette, Bourbon, and Nicholas Counties

Geographic Service Area

Lexington-Fayette County, Kentucky, with recruiting priorities: (1) inner-city public housing sites; (2) North Central Lexington; and (3) county-wide.

Number of Families Served

120 families are served.

Program Philosophy

Project design provides for service delivery through existing agencies and service providers. Project governance is through a Policy Board consisting of Chief Executives of public and private agencies and participants of CCDP.

Services provided and how are they delivered

Adults:

Health services

Comprehensive prenatal, perinatal and postnatal services are provided through the Lexington-Fayette County Health Department, University of Kentucky and private practitioners. Health assessment, coordination, and monitoring of services are provided through the Health Department.

Education, vocational training, employment counseling

Educational assessments, education, training, employment development, counseling and placement are offered by Fayette County Public Schools, the Mayor's Career Resource and Training Center and the Office of Self-Sufficiency Programs, which is located within the Community Action Council (the grantee agency).

Training in infant/child development, health care, nutrition, and parenting

Educational programming is provided by the Council's Office of Child Development staff, Operation Family staff, and a variety of local providers.

Assistance with housing, income support, nutrition

Assistance in these areas is provided by family consultants working with other agencies such as the Department of Social Insurance (income support), WIC, the University of Kentucky's Expanded Food and Nutrition Program, Lexington-Fayette County Housing Authority, God's Pantry, and other local agencies.

Substance abuse education and treatment

Comprehensive services are provided based upon individual needs assessments. Referrals are made to Bluegrass Comprehensive Care Center, the Women's Center and other local providers.

Other services

The project provides intensive case management services with a 1:20 staff/family ratio.

Children:

Health services

The project offers comprehensive pediatric, medical, dental and mental health coverage. Health assessments, coordination and monitoring of services are provided by the Lexington-Fayette County Health Department. Other services provided by the Health Department, the University of Kentucky Medical Center, Bluegrass Comprehensive Care Center and private practitioners.

Early childhood experiences

Assessments are performed by the University of Kentucky Early Child Laboratory. Center-based child development is being provided by the Family Care Center, Growing Together Preschool, the Community Action Council's H.H. Greene Center, and other trained community providers. Home-based experiences are provided by the Council's Office for Child Development. Three and four year old children may attend Head Start or the Fayette County Public Schools' Early Start program.

Child care

Episodic child care is provided by the Community Action Council. Regular child care is provided by the Growing Together Preschool, the Family Care Center, the Council's H.H. Greene Center, and licensed child care providers in the community. Child care funding is available through AFDC/JOBS, JTPA and Title XX programs in Fayette County.

Early intervention for developmental delays

Contracted child development providers complete developmental assessments on all children. Further medical and/or developmental assessments are arranged by the family consultant as needed. Children identified with delays are referred to the Child Development Center of the Bluegrass, Growing Together, and Cardinal Hill Hospital.

Nutrition

Nutrition assessments, counseling, education and assistance (WIC, Child Care Food Program, University of Kentucky's Expanded Food and Nutrition Program, God's Pantry) are provided through a range of public, nonprofit and private health, nutrition and child development providers.

Tennessee CAREs (Comprehensive Area Resource Efforts)

Grantee Agency

Bureau of Educational Research and Services, Tennessee State University

Geographic Service Area

Obion, Gibson, Henry, and Weakly counties in Northwest Tennessee (approximately 250-300 square miles)

Number of Families Served

60 families are served.

Program Philosophy

The goals of the project are to provide comprehensive, intensive, and continuous support services to move families toward self-sufficiency and to promote positive child outcomes. The project is guided by several principles that are fundamental for programs that serve children and families. Specifically, the project believes in, and operates under, the following principles: families play a primary role in shaping a child's development; parents should be the primary decision makers for their families; the first five years are the most critical in a child's development; and the needs of a child cannot be met unless the needs of the total family are addressed. The project also believes that community support is essential to program goals; primary emphasis must be on prevention rather than treatment; the project must be sensitive to and accommodate cultural differences; and that the program should be at the center of an integrated network of services for families.

Services provided and how they are delivered

Adults:

Health services

Family advocates assist families in obtaining health care services. Some education services are provided during parent group meetings. Adults receive routine and prenatal/postpartum care through the area Health Department clinics and through private providers who accept Medicaid payments. Acute health care is provided by the Regional Medical Centers and private hospitals. Mental health care is provided through interagency agreements with the North West Mental Health Counseling Center and Care Counseling center. Dental health care is available on an emergency basis at the Regional Medical Center and through private dentists who accept Medicaid payments.

Educational, vocational training, employment counseling

The project has developed an Economic Self-Sufficiency Advocacy committee. The group consists of business leaders committed to the CAREs project who demonstrate their support by providing both job opportunities and job counseling to CAREs families. A business council has been formed in each of the four counties. A parent self-sufficiency coordinator also works directly with families and employers to assist families in identifying employment opportunities and job training resources. The project works with Job Training Partnership grantees to provide employment training at the Regional Vocational Centers located in the public schools. Adult family members are encouraged to pursue higher education through entrance to degree granting programs at the University of Tennessee Martin campus.

Training in infant/child development, health care, nutrition and parenting

The family advocates coordinate and run weekly parent meetings at the family resource centers. Depending upon the parents' needs these meetings may be social gatherings, educational sessions, or group support activities. Parents also have the opportunity to enhance their parenting skills through participation in activities with their children in the child development classrooms.

Assistance with housing, income support, nutrition

Tennessee CAREs works closely with the Department of Human Resources to ensure that eligible families receive AFDC, Food Stamps, other income support, and Medicaid. Income assistance also is enhanced through the JOBS programs which is administered by the Department of Human Resources and the Job Training Partnership Act. Tennessee CAREs staff work with the Housing authority to place families in Section 8 (HUD) subsidized housing. CAREs staff also have begun working with the Women, Infant and Children Program and local civic and church groups to provide other nutritional services. The CAREs project also has a functional emergency resource fund to aid families in crisis.

Substance abuse education and treatment

The project has interagency contracts with North West Mental Health Counseling Center and Carey Center to provide both inpatient and outpatient substance abuse treatment. These agencies also offer training to family members during the regular Resource Center meetings. The project also provides payment to private physicians when parents request this service.

Other services

Family advocates provide families with transportation to and from the Family Resource Centers using Head Start vans when they are available. The local school

systems are providing the opportunity for family members to become familiar with computers and to enhance computer skills and literacy.

Children:

Health services

Children are provided routine, well-baby care, and immunizations at private physicians or the Department of Health, which is located in each of the four counties. Dental screening and care is provided by private physicians. Acute health care needs are met by the regional Medical Center or private hospitals.

Early childhood experiences

Weekly center-based early childhood experiences are provided to children by the Parent Education Specialist in the child development classrooms. Family advocates also conduct 90-minute, weekly home visits with their families at which time developmentally appropriate activities for program children are provided.

Child care

Family advocates complete a Request for Child Care when a primary caregiver exhibits a need for this service. After the request is completed, verified and approved, the family advocates provide the family with a list of licensed child care providers in the area and assist the families in identifying an appropriate provider. Some of the project's funds are used to purchase licensed child care.

Early intervention for development delays

The project uses the *Early LAP*, the *Hawaii Early Learning Profile (HELP)* and *On Base*. The *Denver Developmental Screening* is used to initially assess the preschool child followed by the *Battelle Developmental Inventory*, if problems are suspected. Further testing may be conducted by staff at the University of Tennessee at Martin Infant Stimulation Program using the *Denver II*. If a delay is confirmed in a child 0-3 years of age, then the Infant Stimulation Program convenes a team of specialists, including the Family Advocates, to design a plan for the child. The child may receive intervention through the Infant Stimulation Center or through a home intervention program. Each case is staffed monthly and reviewed yearly. For children 3 or older, intervention is provided through the public school system.

Nutrition

Children receive nutritional assessments through their mother's participation in WIC. Children also receive a balanced nutritious meal weekly at the child development

classroom. Family advocates check with parents weekly to ensure children are receiving nutritious meals at home.

Other services

Field trips are planned by CAREs staff for children and parents to enhance their learning experiences and to enrich their environment.

Project Focus

Grantee Agency

Grand Rapids Child Guidance Clinic

Geographic Service Area

The "Inner-City" of Grand Rapids, Michigan, including 18 census tracts and extending to the south and southwest from the central business section

Number of Families Served

120 families are served.

Program Philosophy

All services to families must (1) support the families' efforts to mobilize their resources to meet their needs and (2) be provided in ways that strengthen the family.

Services provided and how are they delivered

Adults:

Health services

Health services including prenatal care, acute care, and wellness care are decentralized and provided through 11 Kent County Health Department public health centers, hospitals, and other community health agencies. Also, the Project Focus Field Services Coordinator assumes responsibility for health coordination/monitoring.

Education, vocational training, employment counseling

The project provides opportunities for parents to continue their high school education and obtain a GED through coordination with local school programs and the Department of Social Services. Employment counseling/training are provided by project staff, the Employment Security Commission, the Urban League, and the Area Employment Training Council. Opportunities for career exploration are also offered by project staff and area schools.

Training in infant/child development, health care, nutrition, and parenting

Nutrition education and assessments are provided by home visitors, public health workers, and county extension workers. Education in infant/child development and parenting are provided by home visitors, the developmental specialist, and in classes at the Project Focus Center by Center Services staff. Continued health care education is

provided by home visitors and the Community Center. Parent/toddler and parent/preschooler groups are taught by the early education staff. Parent assistance in transition to kindergarten is provided by project staff.

Assistance with housing, income support, nutrition

Assistance in obtaining WIC, AFDC or income support, housing, clothing, food, etc. is provided by the home visitors, outreach workers, the Health Department, the Department of Social Services, the Urban League, and a Local Community Action Program.

Substance abuse education and treatment

Substance abuse education and treatment are provided by the field services manager and Project Rehabilitation staff, local detoxification programs, and Kent County Health Department.

Other services

Additional services provided by the project include transportation, peer support groups, social/recreational activities, mental health counseling for family members, family planning, and recreational/cultural celebrations.

Children:

Health Services

Physical and dental health screenings and follow-up are provided by home visitors and outreach workers, Public Health, local health clinics. Immunizations are given at the local health clinic. Project staff and a local wellness program offer Fitness/Wellness activities for children.

Early childhood experiences

Home-based early childhood education is provided by the home visitors and developmental specialists at Project Focus. The Kent County Head Start and other pre-school programs (high-risk programs for 4 year old children) are also available.

Child care

Child care for children 2 weeks to 5 years is available for 60 children at the Project Focus Center. In addition, child care slots are purchased from licensed day care homes and child care centers in the community.

Early intervention for developmental delays

Children who are at-risk are first assessed by the Home Visitor/Developmental Specialist team and, if necessary, referred to the Ken-o-sha Diagnostic Center.

Nutrition

Nutritional assessments are provided by project staff, the County Cooperative Extension Service, and the Health Department. Nutritious meals are served at the Focus Center, and nutrition education is provided by the home visitor, Public Health, and County Extension workers.

The WIC program is also available through the Kent County Health Department.

Other Services

Emergency needs such as clothing, food, and rent security deposits are met through the project.

Full Circle Project

Grantee Agency

Western Wisconsin Community Action Agency

Geographic Service Area

Barron, Chippewa, Dunn, Pepin, Pierce, Polk, and St. Croix Counties in Western Wisconsin

Number of Families Served

60 families are served.

Program Philosophy

The Full Circle Project is dedicated to the principle of empowerment, which is an intentional, ongoing process whereby people lacking an equal share of valued resources gain greater access to and control over these resources. The goal of the project is to promote the human growth and development of the families and their individual members. Thus, respectful interaction, a nonjudgmental approach, compassionate support, and flexibility in goal achievement characterize the way this program operates. In addition, where there are noncustodial fathers, the program seeks to enhance their economic self-sufficiency and prosperity and promote the strengthening of their ties with their children where that is in their children's best interest.

Services provided and how are they delivered

Adults:

Health services

The project brokers services for prenatal care and acute health care through County Public Health Departments and private medical and dental providers. Mental health assessments are provided via contract with Unified Services Boards and other mental health professionals working in the region.

Education, vocational training, employment counseling

The program has letters of agreement with the Private Industries Council (PIC) and with the West CAP Jobs and Business Development (JBD) Project. Both agencies provide job training and placement services.

Training in infant/child development, health care, nutrition, and parenting

All project children and their parents receive in-home child development and parent education services. These services are provided weekly. Parents and children also participate in "cluster groups" monthly to increase their socialization and parenting skills. Nutrition is part of the parent education curriculum.

Assistance with housing, income support, nutrition

Full Circle families have priority access to the West CAP emergency funds via contract. When emergency funding is unavailable, payment is made through the Full Circle budget.

Substance abuse education and treatment

The program brokers for substance abuse assistance through existing referral networks and services channeled through (or provided by) 51.42 Unified Services Boards. Family members who cannot be served through 51.42 Unified Boards may be referred to Professional Growth Services of Eau Claire, Wisconsin.

Other services

Full Circle employs a Community Development Coordinator. Her responsibilities include: encouraging local community organizations and institutions to develop linkages with CCDP families, initiating special community projects that include program families, creating community task forces that meet to work on behalf of the project and securing donations of goods and services on behalf of project participants.

Children:

Health services

Comprehensive health and dental services are provided to Full Circle children through contractual arrangements made with County Health Departments.

Early childhood experiences

The program provides home-based child development experiences for all preschool children. It seeks to provide "enriched" day care experiences for all 4 year old children through the purchase of slots from child care providers and through placement of children in Head Start programs.

Child care

Separate agreements with child care providers are negotiated on an as-needed basis. Child care is provided: (1) for families engaged in activities related to self-sufficiency, (2) for respite care, and (3) for children with indications of failure to thrive. Payment is made through the Full Circle budget, when no other source of funding is available.

Early intervention for developmental delays

Early intervention services are provided by Human Services Departments, 51.42 Boards, County Public Health Departments and other special projects in the region.

Nutrition

Nutrition education is provided to project families during the parent education segments of home visits. County Agricultural Extension Office Home Economists provide consultation to the project to prepare field specialists for this responsibility, and direct educational services to parent participation groups.

Project Family

Grantee Agency

Arkansas Children's Hospital

Geographic Service Area

The southeast corner of the Little Rock, Arkansas metropolitan area, including the College Station, Granite Mountain, Sweet Home and East End neighborhoods

Number of Families Served

120 families are served.

Program Philosophy

The first philosophy espoused by Project Family is that the system needs to be flexible and sensitive to the neighborhood, specifically in that the program must deal with the child and family in the context of their surroundings. A cornerstone of the program philosophy is that the receiver of services must also give. People receive much reinforcement from knowledge that they are giving to others; their self-esteem is increased and this translates into increased competence and confidence.

Services provided and how they are delivered

Adults:

Health services

Health care is provided to adults through the Jefferson Comprehensive Care Center, the University Hospital of UAMS, East Little Rock Community Center, and through other health centers in the area. A coordinated system for prenatal/obstetrical care exists to assure appropriate care for individual mothers. The Florence Crittenton Home, a residential facility for unwed mothers which offers services for prenatal care and counseling is available as well. Referrals are made to this facility when clients need to be removed from a particular situation during pregnancy (i.e., drugs or alcohol).

Education, vocational training, employment counseling

The Watershed Project runs GED classes and parent training. The project has parents enrolled in vocational training and in junior college. Watershed also has a job counselor who works to get parents placed in jobs.

Training in infant/child development, health care, nutrition, and parenting.

Project Family has a parent director who is actively involved in the coordination of training and classes for parents. Parent classes are held weekly by the project and cover a range of topics. Recent topics have included safety issues, nutrition and the hard-to-feed toddler, poisoning, child abuse issues, budgeting, child discipline, and self-esteem. Project staff train adults in Family Day Care homes on nutrition, child development and education, sanitation, and safety.

Assistance with housing, income support, nutrition

The project has an emergency fund being used whereby money is given to families in a non-interest bearing loan to help with the emergency/situation. In an effort to work on self-sufficiency with families, the project works out a plan with the families for how the money will be paid back. Assistance with WIC and housing is provided by Project Family staff. The Watershed Project runs a food bank as well which families may access.

Substance abuse education and treatment

The Watershed Project runs a substance abuse education and intervention program which is utilized for referral.

Children:

Health services

Health care for children is part of a coordinated system using the services of the Arkansas Department of Health's Well Child and Primary Care Clinic, and the Jefferson County Comprehensive Care Clinic which provides health care including pediatric care. Also, Arkansas Children's Hospital, various sub-specialty clinics, inpatient services, and a clinic for special needs children are used by program families.

Early childhood experiences

Early childhood experiences are provided in centers and through a home-based model. The project makes use of Head Start, Pathfinders pre-school, the Pulaski Special School District's HIPPY program (Home Instruction Program for Preschool Youngsters), and family day care homes. Case managers are trained in the Partners for Learning curriculum, and carry out appropriate developmental experiences with preschoolers during their home visits.

Child care

There are presently 78 children who are in some kind of child care or day care program. This includes the use of Pathfinders, the Child Development Center (IHDP-II), the IHDP at Arkansas Children's Hospital, Head Start Programs, licensed family day care homes, and various other child care centers. A new child care center is being constructed at the Watershed Project.

Early intervention for developmental delays

The Child Development Center, a satellite school of the Infant Health and Development Program, is run near the project site and provides early intervention services to children under age three. These children have been identified as doubly-vulnerable for developmental problems. A focus of this program is to work with children born to substance-abusing mothers.

Nutrition

Referrals are made to the Arkansas Department of Health, which manages WIC programs for mothers and children under age five; counseling is available, as is provision of certain foods for pregnant mothers, infants, and toddlers. A part-time nutritionist is employed by the project to interact with the WIC program, the Health Department, and the Jefferson County Comprehensive Clinics. The nutritionist also provides counseling for program families and runs group sessions on child nutrition.

Families in Partnership

Grantee Agency

City of Albuquerque

Geographic Service Area

Albuquerque, New Mexico

Number of Families Served

180 families are served.

Program Philosophy

The project's assumption is that city or county governments in many large and mid-sized urban areas are uniquely positioned to organize and manage comprehensive programs for low-income children and families given the wide range of resources generally administered by local government entities, ranging from public housing to job training programs. The conceptual framework that underlies this philosophy is an ecological approach with its focus on the environmental context and the importance of strong positive connections to community institutions.

Services provided and how they are delivered

Adults:

Health services

A comprehensive health (physical, mental, and social) program is being implemented by the University of New Mexico Public Health, Medicine, and Nursing Departments. Families are screened and provided preventive education, health services, and referrals at the multi-service sites and during home visits. Prenatal care is provided through prenatal clinics that offer a full range of services including nutrition counseling and family planning services.

Education, vocational training, employment counseling

Employment counseling is provided by the Employment Specialist at the three CCDP resource centers. Referrals to vocational, ESL, GED, ABE trainings, and job placement programs are made by the family advocates during home visits. Teen parents are referred to New Futures High School, an alternative high school within the Albuquerque public school system.

Training in infant/child development, health care, nutrition, and parenting

Training in these areas is provided in classes at the three CCDP resource centers and during the home visits.

Assistance with housing, income support, nutrition

For AFDC, Food Stamps, and general assistance, families are referred to the New Mexico Department of Human Services. Assistance in obtaining housing is provided through the City Human Services Department's Housing Division, which is the local Housing Authority and offers Section 8, Public Housing, and locally-funded housing options. Assistance with income support is provided during the home visits.

Substance abuse education and treatment

Families receive substance abuse education during home visits. Adults in need of treatment are referred to the city-funded Alcohol and Drug Treatment Program administered by the University of New Mexico Mental Health Center.

Children:

Health services

Health services to children are provided by the University of New Mexico program that serves the whole family.

Child care

Child care for children over three years is provided through City-administered child development centers. For infants and toddlers, child care is provided through child care centers and family day care homes; families are provided vouchers for the purchase of care. Families in Partnership provides technical assistance to family members who would like to become family day care providers.

Early childhood experiences

Most children over three years receive a daily early childhood experience in one of the three child development centers located in the public schools. Early childhood experiences for infants and toddlers are being provided by the family advocates during their bi-monthly home visits.

Early intervention for developmental delay

Children identified as or at risk of developmental delay are referred to Altamira, a home based program for children with disabilities. Medical services for children with

disabilities in several diagnostic categories are available through the State Children's Medical Services Program.

Nutrition

Families are assisted in enrolling for services through the WIC program, which is available at the multi-service centers. All eligible families are provided with assistance in enrolling in the Food Stamp program. In addition, based on assessed need, families are referred to other nutrition services, including surplus commodity distribution, Expanded Food and Nutrition, and emergency food programs.

Primero Los Niños (PLN)

Grantee Agency

La Clínica de Familia

Geographic Service Area

Southern Doña Ana County and Las Cruces, New Mexico

Number of Families Served

120 families are served.

Program Philosophy

The most effective method of enhancing the intellectual, social, emotional, and physical development of infants and young children from low-income families is through a comprehensive, family-centered program that is sensitive to the social and cultural background of the families. The ultimate goal is to promote family unity, independence, and self-sufficiency through the case management approach.

Services provided and how they are delivered

Adults:

Health services

The grantee agency, La Clínica de la Familia, provides most of the health services to program families and children. In addition, pregnant participants are enrolled in prenatal programs that provide prenatal care, and health and nutrition training. Parents go to the public hospitals for delivery.

Education, vocational training, employment counseling

Basic literacy, GED, and ESL classes are available through a local community college. Program parents are referred to community education, employment counseling, college enrollment, and/or vocational training.

Training in infant/child development, health care, nutrition, and parenting

Center-based trainings are provided by PLN staff and consultants, and home-based training is provided by the family advocates, early childhood specialists, and nurses.

Assistance with housing, income support, nutrition

These services are provided during the home visits and counseling activities. They consist mostly of referrals to the appropriate agencies in the community like WIC, AFDC, and others. Nutrition education is provided through the New Mexico Extension Service.

Substance abuse education and treatment

The parent education component provides families with training in substance abuse issues. The family advocates provide necessary linkages and referrals.

Children:

Health services

Screenings, immunizations, referrals, and acute health care are provided to program children through La Clínica de la Familia and existing physical, mental, and dental health agencies in the community.

Child care

PLN has two Child Development Centers and uses center-based care and family day care homes to provide child care.

Early childhood experiences

Experiences to enhance the intellectual, social, emotional, and physical development of infants, toddlers, and preschool children are provided at the two Centers and during home visits to the families.

Early intervention for developmental delay

Early childhood specialists and family advocates identify children with developmental delays and make the linkages with appropriate agencies in the community.

Nutrition

Family nutrition screening and counseling are provided by nutritionists during home visits and in groups sponsored by WIC. Children are provided a nutritious meal at the Child Development Centers.

ShareCare Comprehensive Child Development Program

Grantee Agency

Day Care Association of Fort Worth and Tarrant County

Geographic Service Area

Inner city areas of Fort Worth and Tarrant County, Texas

Number of Families Served

120 families are served.

Program Philosophy

Families' inherent right to autonomy is respected and unconditional acceptance is practiced. These two principles guide all program elements.

Services provided and how are they delivered

Adults:

Health services

Health care services are provided by multiple community agencies. The Public Health Department provides services for mothers and children up to 18 years of age, including screening and referrals; prenatal care; WIC; and dental services. The John Peter Smith Hospital and Cook Children's Hospital provide inpatient care for those who are uninsured. Tarrant County Hospital District and Texas College of Osteopathic Medicine also provide outpatient care.

Education, vocational training, employment counseling

One of ShareCare's objectives is that 90 percent of its clients obtain GED, ESL, vocational training and/or high school diploma or other education so that a career path may be followed. ShareCare requires a career development workshop, develops positions, and provides support after employment. This process is coordinated by a Career Manager.

Training in infant/child development, health care, nutrition, and parenting

In order to address the needs of the child development program, a skilled Child Development Manager has trained all ShareCare center staff. In addition, a child development expert is working as a consultant to assist in the documentation of the program.

Assistance with housing, income support, nutrition

Families in need of emergency resources are referred to the Texas Department of Human Resources, United Way, Catholic Social Services, Emergency Assistance of Tarrant County, as well as several local foundations operating out of the Fort Worth area. A close tie to the Housing Authority facilitates housing problem resolution.

Substance abuse education and treatment

The program has a contractual agreement with the Tarrant Council on Alcoholism and Drug Abuse, which provides services to families in need of substance abuse education or treatment and training for staff and families.

Children:

Health services

Health services for children are provided by the Public Health Department and many resources in the community. A Health Manager coordinates services and assures quality.

Early childhood experiences

Early childhood education services for infants and preschoolers are provided by the Circle Park Center and The Southside Center. For families opting not to make use of the center-based facilities (approximately 10 percent of families), child development experiences are provided in the home.

Child care

Day care is provided at the primary ShareCare facility.

Early intervention for developmental delays

The program screens and assesses all preschool children and coordinates services for early intervention activities with the Child Guidance Clinic, the Child Study Center, CIDC, the Handicapped Consortium, and the Mental Health and Mental Retardation agency.

Nutrition

The Health Manager and Center Directors assure quality nutrition in the centers. WIC eligibility and certification enhances the nutrition component of the program. Parent and child nutrition learning activities also are provided by the project.

Avance Comprehensive Child Development Program

Grantee Agency

Avance, Inc.

Geographic Service Area

San Antonio, Texas

Number of Families Served

120 families are served.

Program Philosophy

Project centers are located in low-income neighborhoods and become the first step to providing integrated support and parenting activities. Avance works with parents to help them discover a new value and capabilities within themselves. The program believes that the early developmental period of children is critical and reminds parents that they are the first and most important teachers of their children. Parents' love for their children and desire for their success provide the initial foundation for Avance's work.

Services provided and how they are delivered

Adults:

Health services

Parents are referred to community health providers. Prenatal care classes are provided semi-monthly for participants who are pregnant. Prenatal care education is also provided during monthly home visits.

Education, vocational training, employment counseling

Basic literacy, GED and ESL classes are offered on-site. Support services such as transportation, child care, advocacy, and networking are offered to project participants who are enrolled in adult education programs. Program parents are referred to community education, employment counseling, college enrollment, and/or vocational training.

Training in infant/child development, health care, nutrition, and parenting

Training in child development (infant stimulation, competency development, cognitive growth), nutrition, and parenting are provided on-site in weekly parent education

classes. Training on early learning through play, parents as teachers, and language stimulation is offered within the Avance Toy Making workshop which is offered on a weekly basis for 8 months to all parents of children birth to one. During the monthly home visits, staff observe parents and their child(ren) during play interactions and sometimes use these interactions as a followup to group trainings. For parents of children three to five, training is provided on a semi-monthly basis. For parents of older children, training is provided on how to parent school-age siblings with monthly groups held at the project sites. In all these groups information is provided about community resources and activities that benefit children and their families. Health care and nutrition education is provided during the monthly home visits.

Monthly nutrition classes are provided for parents of children birth to twelve months through the Texas A & M Extended Nutrition Service. Parents with children older than 2 are enrolled in the homebound Texas A & M Extended Nutrition program for a minimum of six months.

Assistance with housing, income support, nutrition

These services are provided during the home visits and counseling activities. They consist mostly of referrals to the appropriate agencies in the community like WIC, AFDC, and others. Referrals are followed-up within the week following the recommendation. Emergency food, and other goods and commodities are distributed to project families on a regular basis through the center-based and home-based programs.

Substance abuse education and treatment

Mental health services and counseling are provided by project staff and through referral to coordinating agencies. These activities include rehabilitation services for drug and alcohol abuse.

Children:

Health services

Screening, immunization, treatment and health referral are scheduled to be provided on-site for whole groups at one time or by referring children to cooperating health agencies.

Child care

Avance has two Child Development Centers and uses other licensed centers and family day care homes to provide child care.

Early childhood experiences

Developmental experiences are provided at the two Centers and during monthly home visits to the families.

Early intervention for developmental delay

Developmental screenings are provided to all children every six months until the age of 3. An Individual Family Services Plan (IFSP) is developed for children identified as being at risk or delayed, and intervention is provided in the Centers, during the home visits, and through referral to other community resources.

Nutrition

All children in the project are enrolled in the USDA Child Care Food Program for children birth to three. Nutritious meals are provided on-site to children who are attending programs at the Child Development Centers. Nutrition-related concepts are introduced to children participating in the early childhood development program through developmentally appropriate activities .

Other services

Avance provides social, educational, and recreational activities after school and on weekends for school-age children.

Mid-Iowa Community Action (MICA), Inc.

Grantee Agency

Mid-Iowa Community Action (MICA), Inc.

Geographic Service Area

Hardin, Marshall, Poweshiek, Story and Tama Counties in Central Iowa

Number of Families Served

99 families are served.

Program Philosophy

MICA believes empowering families to meet the needs of their children and to become self-sufficient provides the greatest chance for long-term success for families. MICA also believes that empowering communities to be more aware of and responsive to low-income families provides the greatest likelihood for the prevention of poverty. MICA includes an extensive community training program as a part of its research, attempting to bring the highest level of knowledge, awareness and responsiveness to communities to facilitate their work with at-risk families.

Services provided and how are they delivered

Adults:

Health services

Health home visits are conducted by the CCDP/Head Start Health Coordinator. During the health home visits, health histories are conducted and health questions are asked of all family members, in part to determine whether adequate health care services are being accessed. Those adults who have been unable for any reason to receive a physical examination are referred to one of nine local physicians who have agreed to assist the CCDP program by providing free physical examinations.

Education, vocational training, employment counseling

The Family Development Specialists assist families in identifying and planning for their educational/vocational needs. Once needs/goals are identified, the Family Development Specialist assists family members in contacting appropriate programs in the community. CCDP families do not have any priority status for entering Iowa's PROMISE JOBS program.

Training in infant/child development, health care, nutrition, and parenting

MICA's CCDP Home Visitors follow a curriculum that has been developed by the MICA staff in collaboration with staff from the Area Education Agency 6. Parents learn about all aspects of child development including normal child developmental patterns, developmentally appropriate activities, health care and effective parenting techniques.

Assistance with housing, income support, nutrition

Family Development Specialists refer families to local service agencies for assistance in housing, income support, and nutrition.

Substance abuse education and treatment

MICA is aware of the substance abuse treatment services available in the target area and the Family Development Specialists are prepared to make referrals.

Other services

MICA has developed the "Community Academy" program for the purpose of building organizational capacities to respond to the needs of at-risk families and promote collaboration among agencies.

Children:

Health services

MICA operates the WIC and Maternal and Child Health programs which use a medical case management approach in developing individual health and nutrition plans for each child to assure optimal utilization of available resources and the identification of unmet needs.

Early childhood experiences

Home Visitors work weekly with parents from the earliest point of entry into the program. Home Visitors provide a developmental curriculum to parents who use the curriculum with their children.

Child care

A child care/child development survey was administered in November and December 1990 to identify child care needs and preferences among families. The communities in which the program operates have a sufficient number of child care slots available for

CCDP families. Families receive training in selection of safe, appropriate home-based or center-based child care.

Early intervention for developmental delays

Area Education Agencies collaborate on the assessment of delay or risk, and then provide in-home and center-based intervention programs based on age and need of child and family. CCDP Home Visitors work with parents to adapt the child development curricula to AEA recommendations.

Nutrition

The home visitor provides a nutritious food preparation activity in each family's home once a month. When appropriate, the Home Visitor coordinates the family's nutrition education with the education provided by MICA's WIC Program and draws upon the WIC resources.

Project EAGLE (Early Action Guidance Leading to Empowerment)

Grantee Agency

University of Kansas Medical Center

Geographic Service Area

Eastern Wyandotte County, Kansas, bounded on the west by 78th Street in Kansas City, on the north and east by the Missouri River and on the south by the county's boundary with Johnson County

Number of Families Served

120 families are served.

Program Philosophy

Project EAGLE focuses upon empowering families by considering the needs of the whole child and the whole family while respecting family preferences and choices. The project identifies and mobilizes families' strengths to assist them in solving problems and nurturing the development of their children. The project offers services to address the problems of welfare dependency, long social service waiting lists and services that are fragmented.

Services provided and how they are delivered

Adults:

Health services

The project is providing each family with a "medical home" where the families become familiar with the facility and practitioners and are provided care in a consistent manner. Currently, the project is using family practitioners, the Wyandotte County Health Department, the Kansas University Medical Center (KUMC) Obstetrics and Family Practice departments, and several clinics for adult health services including routine, prenatal, and dental care. Mental health services are provided through referral to the Wyandotte Mental Health Department. All family members receive a comprehensive health screening, including a nutrition history, and a physical examination upon enrollment.

Educational, vocational training, employment counseling

The project's Parent Coordinator administers the Basic Life Skills test or provides literacy counseling to parents requesting those services. Job training and further

education are made available through JTPA; the Kansas Private Industry Council; the Kansas City Community College; Donnelly College; the Employment Security Office and Human Resource Development Cooperation; and the Woman's Employment Network.

Training in infant/child development, health care, nutrition and parenting

Child growth and development, nutrition, health, mental health, and substance abuse issues are discussed in weekly parenting classes at the project. Additional classes are provided through the Wyandotte County Health Department, KUMC, Wyandotte County Mental Health Association, and other support agencies. Parenting education and hands-on modeling of child development activities are also provided during home visits made by a family life coach, the Family Advocate.

Assistance with housing, income support, nutrition

Family Advocates discuss social service needs with families during weekly home visits and broker services for families as needed. The WIC program provides nutritional assistance and education. Housing assistance is provided by the local HUD office, Harvest America, Landlords Association, and Wyandotte County Emergency Coalition Network on Housing. A fund to meet families' emergency needs (e.g., food) is available through the Pediatrics Association.

Substance abuse education and treatment

Substance abuse education is provided in project parenting classes and classes for credit at the Kansas City Community College. Substance abuse treatment is provided through referral to the Bethany Medical Center for inpatient care and to the Salvation Army.

Other services

The project is using the *Basic Life Skills* curriculum to help adults evaluate their own levels of knowledge and increase their ability to utilize existing community services. The project also provides participants with transportation through an agreement with a taxicab company. The project sponsors a parent support group for program participants that meets once every 2 weeks.

Children:

Health services

Children receive a comprehensive health screening using the *Early Periodic Screen Development Testing* instrument and a physical examination upon enrollment. Routine, dental, and acute pediatric care are provided by the KUMC Pediatrics and

Family Practice departments, the Wyandotte County Health Department, and private providers. Immunizations and nutritional services are provided by WIC and the Wyandotte County Health Department. Healthy Start follows up at-risk infants with services at its clinic and with home visits.

Early childhood experiences

The Family Advocates conduct early childhood experiences during weekly home visits to families. Each home visit includes 30 minutes for parent education in child development using the *High Scope* curriculum and 15 to 20 minutes of hands-on modeling of a developmental activity, using interaction activities from the American Guidance Services *Small Wonder* curriculum. Parents receive and are encouraged to use a developmental calendar that shows different daily activities for infants. Ross Activities handouts are also available to parents through the project. In many cases, children also receive enriching experiences at Project EAGLE's drop-in child care center, preschool, or through Wyandotte County Head Start.

Child care

Child care is purchased from area providers, including El Centro, Franklin Children's Center, Community Service Center, and Blessed Sacrament School.

Early intervention for development delays

The university provides developmental screenings for all preschool children using the *Denver II* and *Vineland* instruments. Children with suspected delays are referred to the KUMC Child Rehabilitation Unit (CRU) or the Lamb Center for testing. If a delay is confirmed, the child receives therapy from CRU or a specialist hired by the project.

Family Futures

Grantee Agency

Clayton Foundation and Mile High Child Care

Geographic Service Area

Northeast section of Denver, Colorado

Number of Families Served

120 families are served.

Program Philosophy

The project views infant/toddler care as family-focused and developmental. Family Futures is High Scope-based and developmentally sequential with regard to child care and preschool. The project follows the INREAL model for its language training program, and a transactional interaction model for parent-child interaction education.

Services provided and how they are delivered

Adults:

Health services

On-site prenatal care is provided for low- to medium-risk women by the family nurse practitioner. High-risk pregnancies receive services of a perinatal team at Denver General Hospital. A special lactation program is offered as part of prenatal care.

Education, vocational training, employment counseling

Education and vocational training are offered on-site by a number of agencies, including GED, ESOL, family literacy, job training and placement. Providers are the Adult Learning Source, Community College of Denver, and Denver Public Schools.

Training in infant/child development, health care, nutrition, and parenting

Small parenting classes are provided on-site in infant and child development by specialists from Emily Griffith Opportunity School. Specialized courses in health care and nutrition are offered on-site by Denver Health and Hospitals staff and University of Colorado Health Sciences Center. Followup is provided by home-based teams and on-site in the infant/toddler center.

Assistance with housing, income support, nutrition

Staff which comprise the Family/Child Liaison Team provide on-site and in-home case management services. The two DFO Case managers, from Denver Social Services, work at developing resources and linking families to services such as housing and food assistance.

Substance abuse education and treatment

Substance abuse counseling and treatment are provided on-site by Denver Mental Health Corporation with medical management by Denver Health and Hospitals.

Children:

Health services

On-site wellness and illness care are delivered by a family nurse practitioner and supervising pediatrician from Denver Department of Health and Hospitals.

Early childhood experiences

Early childhood experiences are provided through both center-based and home-based delivery systems by the Family/Child Liaison Team. *High Scope* is the curriculum that is being used with children. Specific attention is paid to parent-child interaction and communication skills.

Child care

On-site infant and toddler care and education are provided by Mile High Child care. Child care and education for older children are provided on-site by Head Start.

Early intervention for developmental delays

Children have been screened for developmental problems, and those identified at risk and/or handicapped or medically fragile receive specialized interdisciplinary services by Hope Center, which is an early childhood special education program.

Nutrition

A nutritionist from the University of Colorado Health Sciences Center provides staff training, coordination of nutrition services with WIC, USDA, commodities, and direct services to parents through parent education.

Little Hoop Community College

Grantee Agency

Little Hoop Community College

Geographic Service Area

Reservation of the Devils Lake Sioux Tribe in North Dakota

Number of Families Served

45 families are served.

Program Philosophy

The project takes the philosophy that the health of a society is dependent upon providing an environment that supports the individual and meets his/her needs. Underlying this is the concept of the family, which is viewed as providing the necessary social network to ensure continuity and the development of a healthy, stable social network.

Services provided and how they are delivered

Adults:

Health services

Health care is provided through the Indian Health Service (IHS) clinic for the Devils Lake Sioux Tribe. This includes outpatient services, mental health, dental care, and laboratory and X-ray services. IHS contracts for OB-GYN services through the Lake Region Clinic in Devils Lake, and deliveries are through Mercy Hospital in Devils Lake. Prenatal care is provided through Maternal Child Health, a state funded tribal program, and through the IHS clinic. Acute care is provided through the IHS clinic or through referrals to Mercy Hospital emergency room.

Education, vocational training, employment counseling

ABE, GED and functional literacy is provided at Little Hoop Community College, as is career counseling and vocational training; the college offers carpentry, small machines, and secretarial training. A pre-employment course is available as well for those preparing to enter the labor force, and a wide range of courses are available to parents choosing to pursue higher education. Of the 45 program families, almost 40 are involved in some type of educational or vocational program, or are working.

Training in infant/child development, health care, nutrition, and parenting

In-service workshops are scheduled weekly. The project runs nutrition classes, where groups of parents take a course on meal planning, cooking, budgeting, etc. There is also a nurturing program. Examples of parent education workshops that have been held include *Child Abuse, Alcohol and the Native American Tradition, Business Management, Indian Values, Child and Infant Choking, CPR, Nutrition for Young Children, Making Your own Baby Food,* and *Dealing with Head Lice.*

Assistance with housing, income support, nutrition

Family Support Coordinators work through the Tribal counsel to secure housing and electrical/fuel assistance for families. Nutrition education and assessments are provided through WIC; food pantries are available on the reservation with emergency food supplies for families needing it.

Substance abuse education and treatment

The mental health department at IHS provides substance abuse screening/detection; referrals are made to the Tribal substance abuse program, Family Circle TIPI. The Clinical Social Worker from IHS mental health department provides inservice training and workshops to parents/staff on substance abuse issues. The college has arranged for other speakers to come in as well to educate families on problems/issues associated with alcohol and drug abuse.

Children:

Health services

Health care for children is provided through the IHS clinic and through Maternal Child Health, including immunizations and 6 week check ups.

Early childhood experiences

The project uses The Active Learning Series, by Addison-Wesley for providing child development experiences to children in the centers.

Child care

The project has four child care centers, reserved only for CCDP children. These include Tokio (maximum 20 slots), Crow Hill (maximum 22 slots), St. Michael's (maximum 20 slots), and Ft. Totten (maximum 13 slots). The project has four vans which pick up children at their homes and transport them to and from the child care centers.

Nutrition

WIC provides nutrition assessments as well as hematocrit/hemoglobin screening.

Community-Family Partnership Project (CFP)

Grantee Agency

Center for Persons with Disabilities, Utah State University

Geographic Service Area

Cache and Box Elder Counties in Northern Utah

Number of Families Served

60 families are served.

Program Philosophy

The project's philosophy supports a value-based family partnership approach based on a developmental behavioral model.

Services provided and how are they delivered

Adults:

Health services

As families enter the CCDP program they are sent to the Bear River Health Department (BRHD) for health screening and dental checkups. Medicaid pays for any recommended medical and dental treatment needed. The program can make recommendations to a limited number of private providers who take an occasional patient without medical insurance coverage.

Education, vocational training, employment counseling

Parents needing job training or education are referred to a variety of community agencies.

Training in infant/child development, health care, nutrition, and parenting

Family consultants conduct an average of three home visits a month. During the visits they provide child development experiences through the use of the *Hawaii Early Learning Profile (HELP)* Early Childhood Step Program, Your Child at Play Series, and other program packages. Parenting education is primarily conducted through modeling of behaviors.

Assistance with housing, income support, nutrition

The CFP project expects the project's family consultants to link families with appropriate community agencies. The project intends to expand services or create new services in these areas, as needed.

Substance abuse education and treatment

Referrals are made to community agencies when substance abuse education or treatment is needed.

Children:

Health services

The Bear River Health Department (BRHD) provides the Child Health Evaluation and Care (CHEC) program for people under 21 years who are on Medicaid. BRHD provides health screening at birth, 6 months, 12 months, 18 months, 24 months, 3, 4, and 5 years of age.

Early childhood experiences

The program provides preschool services for 28 three and four year old children. These are provided through arrangements with the CFP Preschool, Head Start Preschools in Logan and Brigham City, the preschool program at Bear River, and the Cache County preschool.

Child care

The program is making an aggressive effort to make families aware of resources for child care. They have developed a data base of available licensed child care facilities in the two counties served, and have prepared maps to show where each program family lives in relationship to approved facilities. In addition, the program has finalized an interagency agreement with several facilities for child care.

Early intervention for developmental delays

Some services for children with identified developmental delays are provided by the nurse at the Bear River Health Department. The nurse, however, is only able to visit the target child about once a month. Children with delays are referred to the Family Intervention project if under age 3, and to the appropriate public school (Logan, Cache, or Box Elder) if over age 3.

Nutrition

The nutritional needs of children served by the program are met by the local WIC program. Nutritional programs are also available through the Food Stamp program and the Well-Child Clinics.

Conocimiento

Grantee Agency

Southwest Human Development, Inc.

Geographic Service Area

Southwestern Maricopa County, Arizona

Number of Families Served

120 families are served.

Program Philosophy

The Conocimiento project uses a family-focused, consumer-generated model with a coordinated and integrated case management component. Services are directed toward facilitating the total development of the children as well as empowering families to enhance their capacity to achieve economic and social self-sufficiency. Conocimiento focuses on encouraging long term planning to reduce environmental conditions that predispose families to be caught in the cycle of poverty and to change policies that create barriers that interfere with the optimal use of available resources.

Services provided and how they are delivered

Adults:

Health services

Adults in need of health services are referred to local health providers. Special linkages exist with the AHCCCS agencies (Medicaid's HMO-type agencies). A dental insurance plan is being developed for families. Mental health counseling is provided by a staff specialist and through referral to community resources.

Education, vocational training, employment counseling

Basic literacy, GED and ESL classes are offered at two Family Resource Centers. The adult education coordinator has developed linkages with other programs in the community where families can be referred for employment counseling, college enrollment, and/or vocational training. Direct services are provided by staff.

Training in infant/child development, health care, nutrition, and parenting

Training in child development, nutrition, and parenting are provided at the Family Resource Centers and during the home visits.

Assistance with housing, income support, nutrition

Family advocates provide assistance as needed during the home visits and through group activities at the Family Resource Centers. Referrals are made to the appropriate agencies in the community like WIC, AFDC, and others.

Substance abuse education and treatment

General information is provided during home visits, workshops at the Resource Centers, and individual and group counseling by project staff. Referrals are made to treatment-based substance abuse counseling and rehabilitation programs.

Children:

Health services

Health screenings, immunizations, treatment, and other health services are handled through referral to cooperating health agencies. Screening and training are provided by Staff Nurses on-site and by family advocates during home visits.

Child care

Conocimiento is working with the housing authority and the school system to develop resources for infant child care in the area. Existing child care resources, such as family day homes and day care centers are being used for toddlers and preschoolers.

Early childhood experiences

Most of the program children receive early childhood experiences during home visits. Some children are referred to child development centers and/or Head Start programs.

Early intervention for developmental delay

All children are screened to assess their developmental status. An IFSP for families of children identified as being at risk or delayed is developed, and intervention is provided during home visits, by the grantee agency (Southwest Human Development), and through referrals to available resources in the community.

Nutrition

Families are linked with existing resources in the community and also receive direct services from project staff, as needed.

Other services

Conocimiento has a School Age Specialist on the staff to provide services to school-age siblings.

In addition to direct services provided to families, the project has focused on changing policies at the Federal, State and local levels that present barriers to success for low-income families. The project also provides opportunities for training to community students in the areas of health, education, and social services.

ENRICH (Enriching Neighborhood Resources for Infants and Children)

Grantee Agency

Venice Family Clinic

Geographic Service Area

Portions of Venice, Santa Monica Mar Vista, Inglewood and West Los Angeles, California, within the area from the Santa Monica Freeway south to the Marina del Ray Freeway, and from the San Diego Freeway west to the Pacific Ocean

Number of Families Served

120 families are served.

Program Philosophy

ENRICH uses a home- and community-based service delivery system which is based on an ecological model—providing comprehensive, coordinated services to meet the individual needs of the family and permit them to intervene in and influence the environment in which their children grow. The goal is to create an environment which maximizes the life potential of project children and empowers their families to live, work and compete successfully in their community.

Services provided and how are they delivered

Adults:

Health services

Physicians at the Venice Family Clinic (VFC -- the grantee agency health clinic) provide free routine and acute health care. Patients receive comprehensive services/screenings when indicated. The Clinic has a collaborative agreement with Bayside Hospital for emergency care. All family members receive an ENRICH gold health card to identify them to the Clinic as CCDP participants; showing the card expedites the medical appointment process. Family members may also elect to receive medical care from private doctors.

Education, vocational training, employment counseling

ENRICH has collaborative agreements with the Eastside YMCA and the Venice Skill Center, an adult educational component within the Los Angeles Unified School District. Reading, literacy, English and other course work leading to a GED, as well as vocational training are also provided. ENRICH has an Employment/Education

Specialist to develop linkages with local businesses, provide on the job development and to help family members become better employed. The Specialist works with families, the Venice Skills Center, St. Joseph Center, and the State/County Employment Department to provide job counseling, training and placement services.

Training in infant/child development, health care, nutrition, and parenting

ENRICH has a parent coordinator who provides/coordinates weekly parent education classes in child development, health care, nutrition and parenting skills. These courses are taught by the Los Angeles Unified School District and VFC staff. Classes are conducted in both Spanish and English. Initial individual education is provided by Family care coordinators during home visits.

Assistance with housing, income support, nutrition

The family care coordinators assist eligible families in applying for AFDC and actively broker for families to help them obtain the limited project housing available. Families receive extra food support from WIC/St. Joseph's Center/St. Gerards. ENRICH has an emergency fund to aid families in crisis.

Substance abuse education and treatment

For outpatient drug abuse services, ENRICH has collaborative agreements with New Start and the Neighborhood Youth Association. Alcohol abuse services are provided by the Clare Foundation.

Other services

ENRICH has purchased two vans and hired one driver to help make services accessible to family members. Family care coordinators have bus tokens/bus tickets and cab vouchers for family members who desire or require this mode of transportation.

Children:

Health services

All basic health care, including screening/assessments, immunizations, dental care, well child care, treatment, and referral for acute care is provided by the Venice Family Clinic or a health provider of the family's choosing. Continuity of care is provided by the ENRICH staff pediatrician who discusses each child's health with the parents while providing educational information on growth and development and nutrition.

Early childhood experiences

All at-home ENRICH preschool children participate in a weekly development program developed from their developmental screening results; the program utilizes different curricula, such as the *Hawaii* and *Banana Briefs*, and is implemented by the family care coordinators. All day care providers include child development activities.

Child care

Child care is provided through an agreement with Connections for Children, an agency which identifies child care slots in family day care homes, provides training on child development and appropriate child development activities to providers, and helps establish family day care providers. In addition, ENRICH is actively pursuing slots in state subsidized child care centers.

Early intervention for developmental delays

All preschool children are screened using the *Denver II* and, when indicated, the *GESSELL*. Children who are suspected of being at risk for developmental delay are referred to a collaborating agency for assessment. If the child is found to be at risk, an individual plan is developed, initiated and monitored. Children who are less than 1 year old are referred to the Regional Center Prevention Program. The Los Angeles Unified School District provides special education programs for children between 2 and 4 years old. For acute problems, coverage under California's Children's Services may be arranged and/or the child may be referred to the UCLA or Harbor Hospital.

Nutrition

Nutrition supplements are available through WIC program. Each child receives a nutritional assessment through the Venice Family Clinic. In addition, nutritional information is brought to the child's home weekly by the family care coordinator.

Other services

Special events and activities are planned for children, such as trips to the circus, museums, movies, family picnics and a Christmas Party.

Families First (FF)

Grantee Agency

Children's Home Society of Washington

Geographic Service Area

South King County, Washington, including Auburn, Enumclaw, Federal Way, Kent, Renton, and the Muckleshoot Indian Reservation areas

Number of Families Served

120 families are served.

Program Philosophy

The FF program embraces the primary principles of the family support movement: prevention; collaboration and parental involvement; mutual-aid and empowerment; comprehensive views of family health and development; flexibility; and acknowledgement and inclusion of the family, and community systems that impact on the child. FF accomplishes this through center-based programs for adults and children, and providing child care. FF also provides a home-based program for families utilizing a multi-team approach. Each family is visited monthly by a family support worker, a public health nurse and an early childhood development specialist.

Services provided and how are they delivered

Adults:

Health services

The Seattle/King County Department of Public Health (SKCDH) provides primary and acute care, WIC nutritional assistance, maternity screenings and prenatal care. The Public Health Department refers patients to local clinics, hospitals and a network of private providers. The public health nurses (PHN) who are contracted by FF have completed health assessments of family members, and provide education counseling on issues identified by the assessments. They assist families in identifying a health plan. The PHNs stress prevention of serious health conditions when possible, and early intervention and treatment when appropriate. FF has contracts with Auburn Youth Resources, Kent Valley Youth Services and Catholic Community Services to provide mental health services to families.

Education, vocational training, employment counseling

Vocational training, employment counseling and job placement are contracted with the King County Work Training Program. They provide a full time counselor at the Auburn Family Support Center. This program offers job readiness skills, assistance with training placement, job search and job placement. An individualized program is developed after the administration of the Adult Student Assessment System and the Reading and Math Assessment. If necessary, remedies and options are discussed and planned. An individual plan is used to establish clear goals and direction. A job board listing vacant positions is provided at Auburn Center and updated weekly for parents.

Training in infant/child development, health care, nutrition, and parenting

Training in infant/child development and parenting is provided by the child development specialist of the home visit team, and in classes which are held twice weekly at each Family Resource Center. In addition, articles are included in the monthly newsletter sent to all families. Training in child development also is provided by the staff of the child care centers. Health care and nutrition are discussed monthly during the home visit of the public health nurses and the family support worker. Additionally, classes are provided through the Seattle King County Public Health Department and WIC offices that cover family planning, education and counseling; education in child development and parenting and modeling of coping strategies, nutrition education, health education and counseling in adult and child health care, including a plan of action for medical emergencies; STD education. FF also provides adult parents and teen parents support groups.

Assistance with housing, income support, nutrition

The family support worker (FSW) monitors housing and income support for the families. The public health nurse monitors the nutrition component. When assistance is needed, the FSW actively brokers with Department of Human Development Services to provide these services. WIC is used for nutrition support as well as the Washington State University Cooperative Extension Service for expanded food and nutrition programs. In emergency situations, FF has a contract with Catholic Community Services to provide for emergency funds for services related to basic needs, home safety, rent deposit, food, clothing, and supplies. The program parents operate their own "Parents Place" which has a food closet and clothing, equipment, and toy loan service available.

Substance abuse education and treatment

FF has a collaborative agreement that assures families are seen within 24 hours of referral with the Southeast Community Alcohol Center (SCAC) which provides screening and assessment for chemical dependency, substance abuse treatment, both

outpatient and referral inpatient, and counseling. The SCAC also provides training to FF's staff and speaks to parent groups. FF provides education through parent classes, a hot line and the newsletters.

Other services

FF has developed a multifaceted transportation system to insure participants access to CCDP services. This system includes 3 vans, Far West Taxi vouchers, and Metro (local bus) coupons. In the Kent and Auburn locations, participants may receive transportation from Dial-A-Ride Van.

FF has a volunteer coordinator to design and develop volunteer programs. Twenty-seven volunteers have been recruited and special events have been orchestrated and initiated such as the Thanksgiving Food Baskets, the Christmas "Holiday Stores" and Adopt-A-Family program. A recycling project has been started. Recently a Community Development Coordinator has been added to the staff to seek and receive donations or other in-kind gifts from the community.

FF also has a strong parent program. Each site has a parent program, a parent council, and a Family Resource Center. Parents have assumed the majority of the responsibility for the FF newsletter. The parents operate "Parents Place," a house donated by the community for resources to enrich participants. Parents actively participate on the Advisory Board.

Children:

Health services

FF provides, through a contract with Seattle King County Department of Health (SKCDH), a comprehensive screening and health assessment for all children, dental care, well child checkup, and immunizations. Emergency and acute medical care are provided through referral at SKCDH. FF has a contract with SKCDH to provide 4 public health nurses who visit each home monthly to ensure preventive health measures are practical and encourage a safe environment.

Early childhood experiences

FF has an individually tailored child care plan based primarily on the Hawaii Curriculum and Native American curriculum for every preschool child. Children receive early childhood experiences through four weekly home visits by the child development specialist and one monthly experience in FF's child care center, or in center based child care that adheres to Head Start Performance Standards. In addition, FF holds weekly parent/toddler and parent/infant courses.

Child care

FF provides infant, toddler and preschool child care—full day, part day, drop-in, and respite care at two centers, one in Kent and one in Auburn, and part day, drop-in, respite care at the Muckleshoot Satellite Office. FF has received $5,000 from King County to train home care providers. FF has contracts with child care centers for full day care that accept DHDS vouchers. FF also contracts with two child care centers in housing projects to provide respite care.

Early intervention for developmental delays

To ensure early intervention for children suspected of developmental delay, FF has all preschool children screened twice. The public health nurse uses the Denver II and the child development specialist uses the *HELP*. From these screenings, individual child development curriculums are developed. If a child is suspected of having a delay by the screening tools or observation, FF has a collaborative agreement for assessment with the Children's Therapy Center. If a delay is found, an individual plan is developed with treatment offered at the center and in the home. Children's Therapy Center provides transportation for the family when needed. The home visit team, public health nurse, child development specialist and home support worker work with the Children's Therapy Center and staff to ensure parents understand and follow through with treatment.

Nutrition

Eligible children receive food supplements through WIC and Cooperative Extension Food and Nutrition Program. The home visit team monitors the nutrition a child receives. All families are invited to receive at least one center based meal a month.

Other services

A toy and infant equipment loan has been instituted so that children have books to see, read, or be read to; have appropriate development toys to stimulate creativity and ensure motor development; and equipment which ensures the child's safety.

In addition, activities are planned for children and their families to participate in that are fun and increase the surrounding world of the child.